KELSEY TRAIL
HEALTH REGION

Annual Report

For the 2014-15 Fiscal Year Ended March 31, 2015

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The Kelsey Trail Health Region Annual Report for the fiscal year ending March 31, 2015 is available on the internet at www.kelseytrailhealth.ca.

Kelsey Trail Health Region is the operating name for the Kelsey Trail Regional Health Authority. Most references to this organization use Health Region, except in reference to the governing board, which is referred to as the Regional Health Authority. Health Region also refers to the geographic areas served by the Kelsey Trail Health Region.

Letter of Transmittal

May 27, 2015

Honourable Dustin Duncan
Minister of Health

Dear Minister Duncan:

The Kelsey Trail Regional Health Authority is pleased to provide you and the residents of the health region with its 2014-15 annual report. This report provides the audited financial statements and outlines activities and accomplishments of the region for the year ended March 31, 2015.

The Kelsey Trail Regional Health Authority is pleased to report several accomplishments during the 2014-15 fiscal year including:

- successful recruitment and hiring of a new CEO;
- completion of the long term care replacement construction and renovation project in Tisdale;
- the sod turning and ongoing construction of the Kelvington & District Integrated Health Care Facility; and
- a regional Accreditation Canada survey resulting in Accreditation with Report.

The overall success of the health region can be attributed to the compassion, dedication and commitment of the Kelsey Trail Health Region's greatest resource – its physicians and employees.

Respectfully submitted,

Rennie Harper
Chairperson
Kelsey Trail Regional Health Authority

Introduction

The 2014-15 annual report presents the RHA's activities and the results of strategies, actions and performance measures identified within the provincial 2014-15 Health System Plan for the fiscal year ended March 31, 2015. This report demonstrates the health region's progress toward meeting 2014-15 targets and commitments, providing an opportunity to assess accomplishments, results and lessons learned while identifying how to improve on previous successes for the benefit of the residents of the health region.

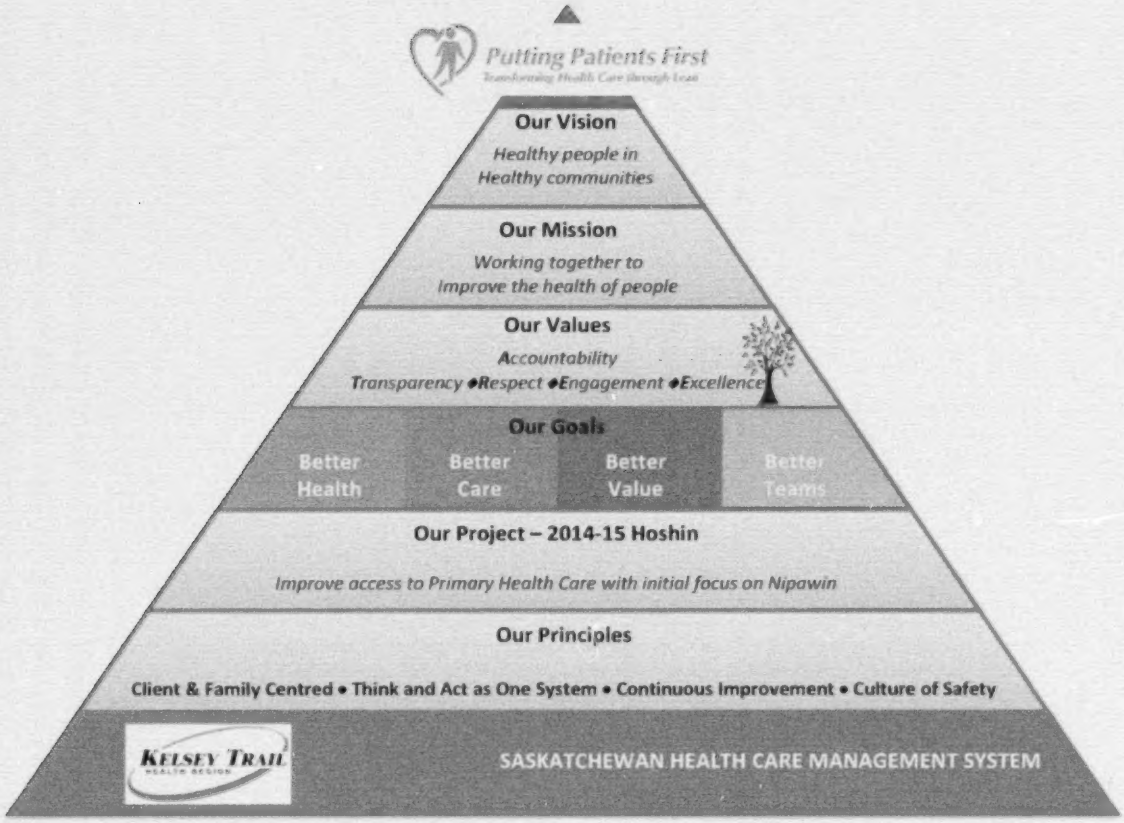
Under Section 55 of *The Regional Health Services Act*, the Kelsey Trail Regional Health Authority (KTRHA) is legislatively required to report on its annual activities. The Authority is collectively responsible for leading the organization in determining, monitoring and assuring appropriate organizational performance. The annual report provides accountability for the activities of the KTRHA to residents and the Ministry of Health.

The information in the annual report is driven by standards, best practise, performance measures and indicators, outcome benchmarks, statistical and environmental data collected by a variety of credible provincial and national organizations and bodies by which the overall performance of health care services and programs are measured. The CEO is accountable for the financial administration and operational control of the health region and is confident the information contained within the annual report is accurate and complete.

Alignment with Strategic Direction

The health region's Vision, Mission and Values reflect the overall direction of the health system. The regional values are aligned with the provincial values of Accountability, Transparency, Respect, Excellence and Engagement.

The *2014-15 Health System Plan* represents the third year of Hoshin Kanri, which features a collaborative approach to determine and achieve strategic priorities through engagement of all levels of staff in a process referred to as "catchball". The establishment of a regional visibility wall and monthly wall walks assist in measuring, reporting and identifying barriers to achieving regional goals and targets. Corrective action plans are developed to address issues that may impact success. Visibility walls and weekly huddles at the facility and departmental level include metrics that are meaningful to frontline staff while supporting regional and provincial targets and goals. Provincial priorities are focused on the 100 Year Strategies: Better Health, Better, Care Better Teams and Better Value which are based on the Institute for Healthcare Improvement's (IHI) Triple Aim. The 2014-15 health system priorities also support targets identified in The Saskatchewan Plan for Growth – Vision 2020 and Beyond.


Putting Patients First
Our Vision
Healthy people in Healthy communities
Our Mission
Working together to Improve the health of people
Our Values
Accountability
Transparency ♦Respect ♦Engagement ♦Excellence
Our Goals
Better Health
Better Care
Better Value
Better Teams
Our Project – 2014-15 Hoshin
Improve access to Primary Health Care with initial focus on Nipawin
Our Principles
Client & Family Centred • Think and Act as One System • Continuous Improvement • Culture of Safety
Kelsey Trail
SASKATCHEWAN HEALTH CARE MANAGEMENT SYSTEM

Through the evolution of the Hoshin Kanri process, some of the provincial five year outcomes identified in 2013-14 were further revised in 2014-15. One provincial Hoshin, an area for breakthrough improvement over a 12 to 18 month period, was identified in 2014-15: *At least 85% of patients requiring admission from emergency department are admitted to an appropriate bed within 5 hours.*

The provincial breakthrough initiative influences and guides the strategic priorities of the health region and impacts achievement of the provincial three to five year outcomes. Long waits in the emergency department are a symptom of multi-faceted issues affecting patient flow across the continuum of care.

The *2014-15 Accountability Document* issued annually by the Ministry of Health clarifies the priorities, expectations and reporting requirements of the Regional Health Authority. It complements existing legislation, regulations, contracts, ministerial directives and policies, and establishes expectations based on targets set in the provincial *2014-15 Health System Plan.*

Regional strategic planning is influenced and impacted by financial, operational, capital and human resources.

A commitment to a culture of safety, patient and family-centred care, continuous improvement and thinking and acting as one are the foundations upon which all provincial and regional health system planning are based. Supporting provincial documents such as For Patient's Sake – Patient First Review Commissioner's Report to the Saskatchewan Minister of Health, the Saskatchewan Surgical Initiative (SKSI) Plan, the Primary Health Care Framework, the Saskatchewan HIV Strategy 2010-14, as well as the standards set by Accreditation Canada, the Canadian Standards Association (CSA) and *SaferHealthcareNow!* (SHN) also shape strategic priorities.

Total Population	Seniors (65 & older)	Aboriginal Population
42,650	19.66%	10.36%

Overview

The RHA is responsible for providing safe, quality, timely, effective and efficient primary and secondary health care services to the population of the region. Services are available and accessible to residents as reasonably close to home as possible. At 44,369.62 square kilometres, the region has a large geographic footprint which includes 58 rural and urban municipalities, five First Nation communities and the Northern Village of Cumberland House. The region has a population density of 0.96 persons per square kilometre.

According to 2014 Covered Population statistics, the total population of the region has increased slightly over the previous year. Only residents registered for provincial health coverage are included in the Covered Population, which may not include everyone who is a resident of the province as of June 30th.

Over 30 physicians and 1,600 staff provide a broad range of community and facility-based services and programs. Physician resources include a Chief of Staff/Vice-President of Medical Services, a Medical Health Officer, a resident General Surgeon, a visiting Radiologist, General Practitioner /Anaesthetists, and General Practitioner/Obstetricians. Accessible itinerant services are provided by a number of visiting physician specialists at district hospitals in Melfort, Nipawin and Tisdale. Associate privileges are also granted to dental and chiropractic service providers.

Visiting Specialist Services

Ear/Nose/Throat
Obstetrics/Gynecology
Ophthalmology ♦ Orthopedics
Plastic Surgery
Podiatry ♦ Psychiatry
Urology ♦ General Surgery
Respiratory Medicine
Exercise Stress Testing

Kelsey Trail Health Region (KTHR) provides varying levels of acute care services from three district hospitals, three community hospitals and four health centres within the region. The region also operates ten long term care facilities, which include four Dementia units. In some cases, KTHR partners with other agencies to deliver services to First Nation communities in the region.

Pre-hospital emergency care is available through a combination of RHA-owned and contracted emergency medical services. Trained volunteer First Responders and Ancillary First Responder groups provide emergency services to a large number of communities and areas in Kelsey Trail.

District Hospitals
Melfort ♦ Nipawin ♦ Tisdale
Community Hospitals
Hudson Bay ♦ Kelvington ♦ Porcupine Plain
Health Centres
Carrot River ♦ Cumberland House ♦ Rose Valley ♦ Smeaton
Long Term Care Facilities
Arborfield ♦ Carrot River ♦ Hudson Bay ♦ Kelvington ♦ Melfort Nipawin ♦ Porcupine Plain ♦ St. Brieux ♦ Tisdale

Primary Health Care Sites

Arborfield/Carrot River
Cumberland House
Hudson Bay ♦ Kelvington
Naicam ♦ Nipawin
Porcupine Plain ♦ Tisdale

Primary Health Care (PHC) services are accessible throughout the region and are delivered by healthcare professionals in a collaborative, team approach. Along with Community Health Services, PHC focuses on community development and population health promotion.

The region has a well-established Saskatchewan Telehealth video conferencing program which provides a link for rural and urban health care professionals to schedule specialist appointments, consults, clinical visits and follow-up appointments for patients and clients. It is also used for educational sessions for health care professionals and members of the public.

Volunteer services are coordinated through the Human Resources (HR) department. Volunteers provide countless hours of service to the region every fiscal year. More detailed information about the services provided by Kelsey Trail Health Region can be found on the region's website at www.kelseytrailhealth.ca.

Community-Based Organizations

The region acts as the accountable partner in contractual relationships with a number of independent Community-Based Organizations (CBOs) and third parties for the delivery of health care services. CBOs receive funding from KTHR to provide health services. KTHR is responsible for financial monitoring, ensuring adequate resources are being provided, and accountability among CBOs.

KTHR has contractual relationships with several emergency medical/ambulance services operating within the boundaries of the health region in Kelvington, Tisdale Rose Valley, Nipawin

and Melfort as well as the Nipawin Oasis Community Centre Cooperative which provides services for clients with long term mental illness in the Nipawin area.

Partnerships

Kelsey Trail has developed a number of mutually beneficial partnerships that provide strong connections to community, enhance resource-sharing opportunities and have long term impact on meeting the needs of the population.

Ministry of Health: provides strategic and policy direction, sets and monitors standards, provides funding, and supports the health region to ensure the provision of essential and appropriate services to residents.

Health Shared Services Saskatchewan (3sHealth): provides select administrative and support services through a shared services model, including payroll and group benefits administration and contract administration for group purchasing.

Saskatchewan Association of Healthcare Organizations (SAHO): provides labour relations services, including collective bargaining, as the representative employers' organization.

Prince Albert Parkland Health Region (PAPHR)/Sunrise Health Region (SHR): partners with PAPHR for mental health inpatient services, 24-hour emergency mental health referrals and consultations, specialty mental health services such as psychiatry, eating disorders and psychologist supervision; orthopaedic surgical services at Nipawin Hospital; and biomedical engineering technology services. The region also partners with PAPHR and Sunrise Health Region on the F.A.S.T. Stroke Bypass Protocol.

Athabasca Health Authority (AHA): partners with AHA to provide Information Technology support.

Saskatoon Health Region (SHR): partners with SHR in the provision of pathology services as well as Privacy support and services by the SHR Privacy & Access Office.

North East Regional Intersectoral Committee (NERIC): partners on the NERIC which includes the North East School Division, Cumberland College, the Ministry of Social Services, Métis Nation Eastern Region 1 & 2, and several other human resource agencies. Through this partnership, the region facilitates and supports community-based approaches and initiatives in response to the needs of children, youth and families.

KidsFirst: accountable partner for the *KidsFirst* targeted program in Nipawin and non-targeted regional program, a voluntary program that works in collaboration with existing community programs to help vulnerable families, enhance knowledge, provide support and build on family strengths.

Nipawin Community Mobilization Unit – Nipawin Hub: partnership with the North East School Division, Ministry of Social Services, Ministry of Justice, Nechapanuk Child and Family Services, Town of Nipawin, Northeast Regional Intersectoral Committee and the RCMP to develop a multi-agency collaboration focused on reducing crime and victimization and supporting a safer, healthier community. The Community Mobilization – Nipawin Hub approach is modeled after the Prince Albert Community Mobilization Program and is supported by the Government of Saskatchewan's Building Partnerships to Reduce Crime initiative (BPRC).

Saskatchewan Cancer Agency (SCA)/Saskatchewan Heart & Stroke Foundation: partners with the SCA to operate the Screening Program for Colorectal Cancer targeting men and women between 50 and 74 years of age who are at risk of developing colorectal cancer. The SCA also has a unique partnership with the region as a sitting member of the KTHR PHC Population Health team and the region's Eat Well, Play Well group. The Saskatchewan Heart & Stroke Foundation is also represented on the KTHR PHC Population Health team, the Eat Well, Play Well group, the region's Tobacco Working Group and Healthy Weights Working Group.

Cumberland College/Saskatchewan Polytechnique/University of Saskatchewan: partners with all three educational institutions to provide practicum opportunities for post-secondary students in health-related fields to meet their educational needs. Institutional Cooking and Continuing Care Aide programs were offered in KTHR in 2014-15. A secondary apprenticeship program for those completing the first level of Institutional Cooking is in the process of being designed.

Union Affiliates: respectful partnerships with the Saskatchewan Union of Nurses (SUN), the Health Sciences Association of Saskatchewan (HSAS) and the Saskatchewan Government & General Employees Union (SGEU).

Municipal Stakeholders: regularly partners with municipal bodies to address program and service needs. The health region is working with the Town of Kelvington, Town of Tisdale and surrounding municipalities on two capital projects. In Tisdale, KTHR was involved in a partnership with the Town in the development of a community health complex.

Other significant partnerships include community foundation and trust committees and auxiliaries, Health Quality Council (HQC), Prince Albert Grand Council, Saskatoon Tribal Council, Métis Nation Eastern Region 1 & 2, Lakeland District Sport Culture & Recreation and North Sask Laundry & Support Services.

Administrative Structure

The Chief Executive Officer (CEO) works with an Executive Management Team that includes four Vice Presidents. The Executive Assistant to the CEO and Corporate Communications Officer serve as resources to the Executive Management Team.

The CEO reports directly to the Regional Health Authority (RHA) regarding the general and daily operations of the health region. The Executive Management Team is responsible for effective planning, integration and delivery of facility-based and community-based programs and services and reports directly to the CEO. The Executive Management Team is also responsible for the overall operation of the health region. Communication with the Management Network (regional directors, facility administrators, program and nursing managers) occurs through a combination of teleconferences and face-to-face meetings.

In April 2014, the former Vice President Corporate Services was officially appointed CEO. Soon after, the Executive Team and Senior Leadership Team were restructured. Portfolios were reconfigured and the former VP Institutional & Emergency Care became the VP Integrated Health Services, adding Home Care, Primary Health Care and Therapies to a portfolio that also includes Acute and Long Term Care. The former VP Community & Primary Health Care role became the VP Health Safety & Culture which includes Human Resources, Mental Health & Addiction Services, Public & Environmental Health and the Kaizen Promotion Office (KPO). The former VP Finance & Information Services role became the VP Corporate Services which includes Finance, Building, Food & Nutrition, Laundry, Environmental and Information Management Services, Materials Management and Capital Projects.

In March 2015, restructuring within the Support Services portfolio at the senior leadership level was announced. Support Services expanded to include Building Services in addition to Environmental, Laundry and Food Services. Recruitment for a Director of Support Services was expected to begin in April 2015.

Within senior leadership, in May 2014 the Director Information Technology was temporarily expanded to assume the portfolio of Building Services from the Director Materials Management & Building Services until March 31, 2015.

Governance

The KTRHA is responsible for the planning, organization, delivery and evaluation of the health services it is directed to provide by the Ministry of Health. The RHA functions primarily as a "committee of the whole". During the year, the four committees of the RHA were restructured and now include: Quality & Communications, Finance, Audit & Risk Management, Practitioner Liaison, and Governance & Human Resources.

The Authority utilizes a broad range of informal consultations to gather information on community issues, needs and priorities related to healthcare. In addition to existing intersectoral partnerships and relationships, the RHA and Executive take advantage of opportunities to meet with representatives of municipal councils and First Nations chiefs and councils. The RHA has had extensive, ongoing consultation with municipal councils and community champions in relation to the capital projects at Kelvington and Tisdale.

The health region utilizes a variety of formats to communicate with and engage the public. These include regular monthly RHA meetings; community wellness assessments and other community-based events and activities; newsletters and publications; the public website (www.kelseytrailhealth.ca); several regional and weekly newspapers, newsletters and radio stations. More recently, KTHR has utilized social media to engage with stakeholders. Regular contact with stakeholders and partners is maintained through a combination of email and regular mail distribution of information and publications. The RHA chairperson, CEO and other designated representatives are involved in meetings with municipal councils, community groups, partner agencies, community trust committees and/or foundations and the general public.

Members of the Kelsey Trail Regional Health Authority include (Back, L-R): Gordon Cresswell, Frank Garchinski, chairperson Rennie Harper, vice-chairperson Clarence Hendrickson, Rick Radom, (Front, L-R) Darrel Guy, Nancy Steinbachs, Dennis Koch and Kathy Bedard.

Employee Demographics

The KTHR workforce includes 1,683 total employees representing 1077.46 full-time equivalents (FTEs). Of those, 25.6% are casual. In total, almost 43.72% of the regional workforce is 50 years or older. The regional workforce is comprised of approximately 91% females. Seventy-five, or 4.45% of the region's total employees have self-identified as Aboriginal since 2007-08.

A significant percentage of KTHR employees are long term. Sixty-five employees retired in 2014-15. In total, 208 current employees reached Rule of 80 retirement eligibility as of March 31, 2015. By March 31, 2018, an additional 95 employees will reach Rule of 80 retirement eligibility.

The single largest challenge the region faces is recruitment and retention. The region experiences challenges in recruiting and retaining Registered Nurses, Nurse Practitioners, Continuing Care Aides (CCAs), Therapists (occupational and physiotherapy), Pharmacists, and Lab and Diagnostic Imaging technicians. Labour shortages in any of these areas have the potential to impact patient, client and resident care. In March 2015, KTHR hosted a successful nursing recruitment day in Saskatoon in an effort to recruit both graduate and experienced nurses interested in pursuing full-time career opportunities in rural Saskatchewan. KTHR worked with Cumberland College this year to offer a Continuing Care Aide (CCA) course in Nipawin to address the educational needs of approximately 15 conditionally hired employees in Carrot River and Nipawin and is exploring opportunities to offer similar programming in other communities in the future.

In 2014-15, physician resources in KTHR continued to stabilize. The health region gained six new physicians and lost five during the course of the year. Due to retirement, the region also lost the services of the regional pediatrician in February 2015. The recruitment and retention of General Practitioner/Obstetricians and General Practitioner/Anaesthetists continues to remain challenging and can impact the region's ability to provide labour and delivery services, and deliver surgical services. The region hosted a successful Saskatchewan Medical Association (SMA) tour of medical students in January 2015 which included practical experience at a number of hands-on clinical stations and tours at Melfort Hospital before an afternoon of downhill skiing and socializing. The event provided the region with the opportunity to make connections and introduce future Canadian graduates to rural, family medicine.

Emerging Health Issues

The health region works collaboratively with the Ministry of Health and Health Canada to maintain an awareness of emerging health issues. They are identified and addressed on the basis of priority.

Populations lacking or having difficulty accessing one of more of the determinants of health may be subject to disparities in health. Within KTHR, many people face challenges in accessing the resources that help achieve physical, mental and social well-being and directly impact overall health.

Adequate housing and food security are key determinants of health and the overall well-being of the population. The Northeast Housing Research Project revealed a shortage of affordable rental stock and waiting lists in Melfort, Nipawin and Tisdale.

Food security issues may result in poor diet choices that can contribute to higher rates of diabetes and obesity. According to The Cost of Healthy Eating in Saskatchewan 2012, a report by the Saskatchewan Food Costing Task Group, many factors influence individual ability to make healthy food choices.

Determinants of Health

- *Income*
- *Social Support*
- *Education & Literacy*
- *Employment & Working Conditions*
- *Social Environments*
- *Physical Environments*
- *Personal Health Practices & Coping Skills*
- *Healthy Child Development*
- *Biology & Genetic Endowment*
- *Health Services*
- *Gender & Culture*

Health Canada

According to the Indigenous Peoples' Health Research Centre, Aboriginal communities have identified their priority concerns as socio-economic status; mental health and addictions/trauma; and chronic disease – high rates of smoking and diabetes. KTHR Primary Health Care Provider Teams Community Wellness Assessments conducted in 2013 indicate local health concerns are similar to those expressed by Aboriginal communities and include adult overweight/obesity, cancer, heart disease and stroke, diabetes and mental health. Community Wellness Assessments will be repeated in May 2015.

Chronic conditions can be risk factors for one another. The presence of chronic conditions such as diabetes and hypertension increases the risk for another by about three times. The risk of chronic disease is also influenced by other factors such as smoking, obesity and physical inactivity. Many of the health concerns identified in KTHR are linked to the high rates of co-morbidity among chronic conditions in KTHR as well as higher rates of other contributing risk factors.

As compared to the provincial averages, KTHR residents have high rates of cancer incidence; cancer prevalence; incidence of hypertension; hospitalization for acute myocardial infarction (AMI); prevalence of diabetes; incidence of diabetes; self-injury hospitalization and suicide. Rates of self-reported overweight or obesity are also higher in KTHR than the province. Information and data on the health status of the residents of Kelsey Trail Health Region is

available from the Statistics Canada Health Profile, the Canadian Institute of Health Information (CIHI) Your Health System report and through the Health Quality Council's Quality Insight. A snapshot of the region's current state is also available on the KTHR website. The provincial Health Status Report provides analysis of data and trends, describes the health of the population, and highlights issues related to the health of the population.

Progress in 2014-15

The Ministry of Health develops and issues an annual document clarifying the performance relationship between the Ministry and the health region. The *Accountability Document* is focused on strategic directions for the health region and the Ministry's expectations for the region, complementing existing legislation, regulations, contracts, Ministerial directives and policies. All assumptions and accountabilities within the *Accountability Document* are prepared within the strategic priorities as outlined in the *2014-15 Health System Plan*. Focusing on the 100 year strategies of better health, better care, better values and better teams, these areas of emphasis translate the region's vision, goals and priorities into a comprehensive set of performance measures and targets which provide a framework for achieving organizational improvement strategies directed at meeting the provincial three to five year outcomes as outlined in the *2014-15 Health System Plan*. The regional priorities also reflect commitments made in *Saskatchewan's Plan for Growth,* the *Speech from the Throne 2013,* to Accreditation Canada and the Minister's letter to the KTRHA Board Chairperson.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to have people living with chronic conditions experience better health as indicated by a 30% decrease in hospital utilization related to six common chronic conditions (Diabetes, Coronary Artery Disease (CAD), Coronary Obstructive Pulmonary Disease (COPD), Depression, Congestive Heart Failure, Asthmas) by March 31, 2017.

Improvement Target

By March 31, 2017, there will be a 50% improvement in the number of people who say "I can access my Primary Health Care (PHC) Team for care on my day of choice either in person, on the phone, or via other technology.

KTHR Hoshin/Project: Improve access to Primary Health Care with initial focus on Nipawin

- The ideal state for Primary Health Care access in Nipawin would be that patients could access their team for care on their day of choice providing continuity of care for the patient. Team members would be accountable, work to full scope and would have work-life balance. Services would be provided to at-risk populations in a venue that enables access and promotes wellness.

- Root cause analysis of access to physician services in Nipawin indicates residents of Nipawin and area are unable to see a Physician or Nurse Practitioner on their day of choice.
    - It is estimated that approximately 30% of people visiting the outpatient department do not have a family physician. Physicians are not taking on any new patients.
    - A large First Nation population accesses health care in Nipawin.
    - There is a high incidence of chronic disease in the Nipawin area.
    - The Quality of Care Coordinator receives client concerns regarding access.
    - Patients are confused about where and how to access health care.
- KTHR concentrated physician recruitment efforts on Nipawin and by August 2014, a full complement of family physicians had been successfully recruited to Nipawin. For the first time in several years, Nipawin physicians began accepting new patients.
- Access continues to be an issue therefore improvement work shifted to gaining an understanding of physician demand, including the number of patients being deferred.

Measurement Results:

Work on the Nipawin Primary Health Care breakthrough initiative began prior to the 2014-15 fiscal year and included Value Stream Mapping (VSM) in both clinics in Nipawin. Through the VSM process, baseline data for measuring same day access in its current state was collected for each clinic.

Some of the challenges with receiving access on day of choice that were identified included:

- clinics limiting appointment bookings to four weeks in advance;
- patients without primary providers, and;
- multiple demands on physician schedules including Emergency Room (ER) call, satellite clinics, surgical assists, anaesthetics and obstetrical call.

The patient empanelment process, the act of assigning individual patients to individual primary care providers, also started in February 2014. A number of milestones were achieved during the 2014-15 fiscal year which had a positive impact on the ongoing progress of this project.

July 2014	September 2014	October 2014	November 2014	December 2014	January 2015	February 2015	March 2015
Data Collection and input into "Transform My Practice" started in clinics	Patient invited to participate on Hoshin team	RPIW #5 Reduce the lead time for patient scheduling in Nipawin Primary Healthcare by 50%	Determine # care providers needed in clinic/day	Shared Leave Calendar for providers	Develop provider master schedule	Implement Visual Daily Management in clinics including tracking of unfilled appointments	Implement electronic locum form for providers

A team including physicians and staff from both Nipawin clinics participated in a Rapid Process Improvement Workshop (RPIW) event focused on reducing the lead time for patient scheduling in Nipawin Primary Health Care by 50%. The general theme of the RPIW was to improve access to patient care by reducing wait times to book appointments, and levelling physician out-of-clinic time to improve continuity of care.

- In the current state, both clinics were seeing less than 100 patients per day 80 percent of the time. By having a minimum of five providers in the community at all times with each physician seeing a minimum of 20 patients per day and each Nurse Practitioner seeing a minimum of 15 patients, the clinics hoped to achieve the 100 patient per day target and meet demand.

- As the result of the RPIW, a 30 day rolling schedule for booking patients was developed and implemented; appointments were standardized for providers at both clinics; a master schedule was developed for providers; standard work was developed for providers, clinic staff and schedulers; and a visual daily management process was developed.

The audit process has revealed the team has experienced challenges sustaining some of the gains realized through the RPIW including having the minimum five providers in the community at all times, maintaining the 30 day rolling schedule, and maintaining a master schedule for providers. The team continues to work to address these issues through improvement initiatives focused on communicating and updating standard work for scheduling, a same-day appointment marketing strategy directed at rerouting non-urgent ER patients to fill clinic appointments, the implementation of a master schedule for providers and advance awareness of when the five provider minimum will not be in place.

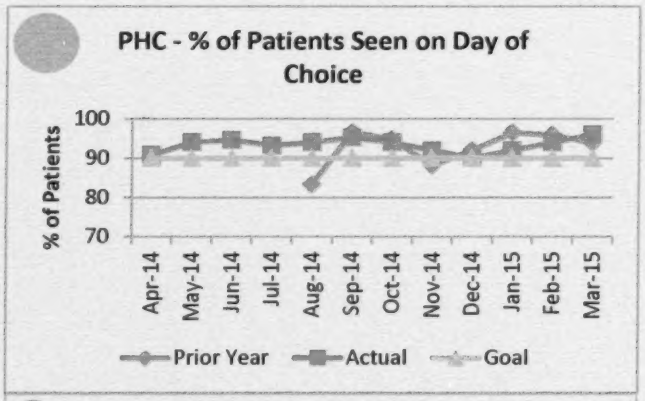
Ongoing improvement work will continue in 2015-16 in an effort to meet and sustain the improvement targets that have been established with a goal to progress to become daily work in the following fiscal year.

Measurement Results:

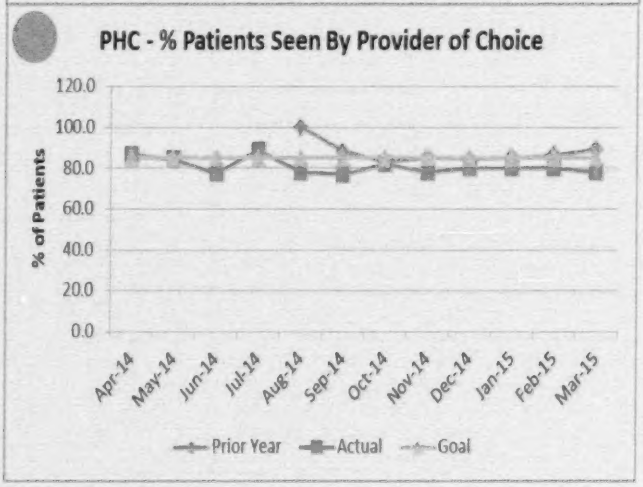
Percentage of primary health care patients reporting they can get an appointment on their day of choice.

Regionally, KTHR met the 90% target. Clinician turnover and access remain a priority and an issue. The goal is to maintain this standard while working through other foundational actions throughout the region, such as empanelment.

Data for this measure is collected quarterly through HQC patient satisfaction surveys. This information is obtained from clients at the clinics for appointments. While a number of factors impact the region's ability to achieve this goal, the number of days and number of hours Physicians and Nurse Practitioners are in the clinic has the most significant influence.



KTHR is also measuring the percentage of patients seen by their provider of choice and has established a target of 85%. In 2014-15 the region did not meet the target.



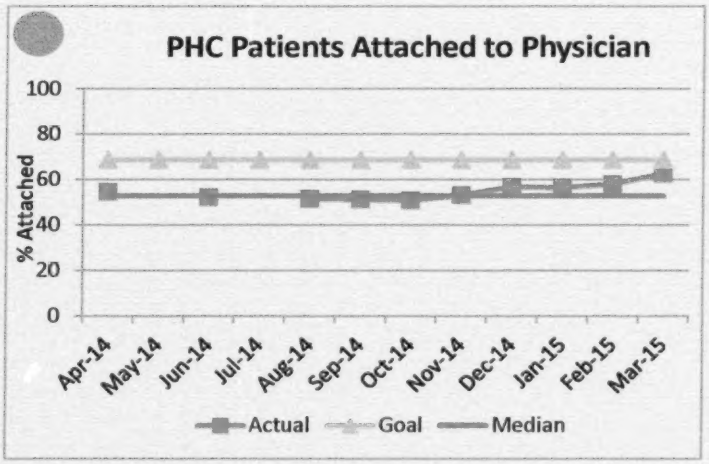
Date Prepared: 04/27/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

Data on this measure is collected through the Primary Health Care Experience survey. Surveying began in November 2013 in Arborfield, Carrot River, Cumberland House, Hudson Bay, Kelvington, Naicam, Nipawin, Porcupine Plain, Red Earth First Nation, Shoal Lake, Smeaton and Tisdale. Patients receiving primary health care services at these sites are asked to complete the survey at the conclusion of their visit. The survey goal is 20 per month per site.

Health Quality Council (HQC) houses the survey data and develops reports which are provided to clinicians, clinic groups and the health region. The data provided will be used to establish a baseline. The survey data is collected from patients that are able to access an appointment however this tool does not provide data on the number of people that call for an appointment and cannot get one.

Percentage of Saskatchewan residents who are connected to a family physician or primary health care team as their usual provider of care.

KTHR started collecting baseline data for this measure in the 2014-15 fiscal year. The region established a target of 70% empanelment by March 2015. Although KTHR did not reach the target in 2014-15, there was steady improvement over the course of the fiscal year.

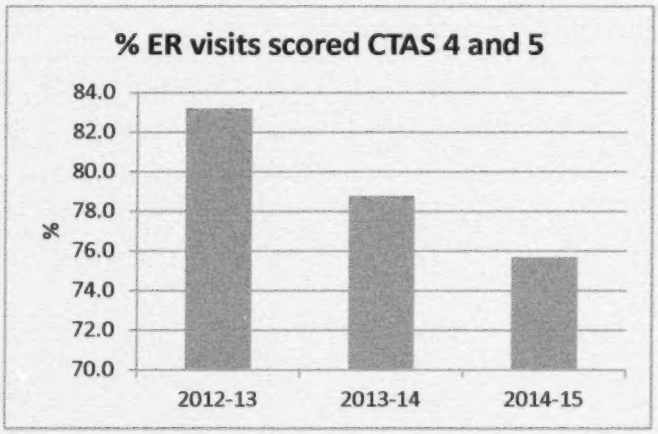


Date Prepared: 04/27/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

There is a significant education and process work that needs to occur to reach this target which has intentionally been set high. In KTHR, patients are already attached to Primary Health Care teams. The goal is to attach every patient to a provider in order to improve continuity of care. There is a significant difference in continuity of care if patients always see the same primary provider but also have access to a provider team to meet all of their healthcare needs.

Percentage of emergency department visits that are scored as Level 4 or 5 on the Canadian Triage Acuity Scale (CTAS).

Overall, there has been a decrease in the total regional number of emergency department visits scored as CTAS level 4 and 5 over the past three years. CTAS 4 and 5 patients are considered to have less urgent or non-urgent conditions that should be seen in the clinic rather than the emergency room.



Date Prepared: 04/27/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

Between 2012-13 and 2014-15, there has been an 8.9% decrease in those scored CTAS level 4. Over the same period, CTAS 5 levels have decreased 27.5%.

Rural acute care facilities in KTHR do not have a dedicated ER physician. ER call is one of multiple demands on physicians. Depending on location, demands also include anaesthesia, surgery, obstetrics and satellite clinics out-of-town in addition to regular family medicine practice.

KTHR tracked the number of CTAS 4 and 5 visits to all six emergency departments in the region. Improvement work accomplished through the Melfort ER Hoshin project in 2013-14 continued as daily work in 2014-15 and replication work was initiated in other acute care emergency departments throughout the region.

Value stream mapping was completed at all KTHR acute care emergency rooms in 2014-15, identifying a high level overview of the current state of CTAS 4 and 5 patients accessing emergency room services. Future state maps were developed for all six acute ERs, kaizen bursts were identified and improvement plans were developed and implemented.

The majority of patients visiting KTHR acute ERs are CTAS 4 and 5. Some of the challenges noted through the VSM process were that some patients are not aware of the process to access a physician if their family physician is not available or if they do not have a family physician. Many patients are not attached to a provider. Improvement work at ERs has included redirecting CTAS 4 and 5 clients back to the physician clinic. A number of PHC clinics have concentrated improvement work on increasing the availability of same day appointments. Clinic access has the most significant impact on this measure.

Improvement Target
By March 31, 2020, 80% of patients with six common chronic conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, heart failure, depression, and asthma) are receiving best practice care as evidenced by the completion of flow sheets available through approved electronic medical records (EMR) and the EMR viewer.

KTHR Results:

Best practice guidelines for Diabetes and Coronary Artery Disease (CAD) are currently available to all KTHR Physicians, Nurse Practitioners and allied health providers via the Electronic Medical Record Chronic Disease Management Quality Improvement Program (CDM QIP) templates. The templates were rolled out to KTHR providers during the last fiscal year. The CDM QIP is a partnership between the Saskatchewan Medical Association and the Ministry of Health.

In 2014-15, PHC started discussions surrounding establishing the percent of patients receiving care consistent with best practice guidelines for chronic conditions. Due to capacity issues work

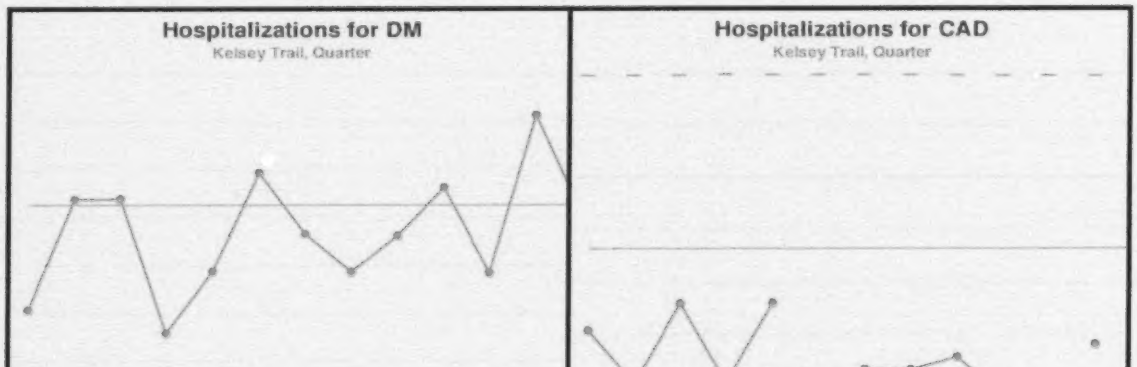
has not been started in this area. Roll out of the templates for chronic obstructive pulmonary disease (COPD) and heart failure is expected in the 2015-16 fiscal year.

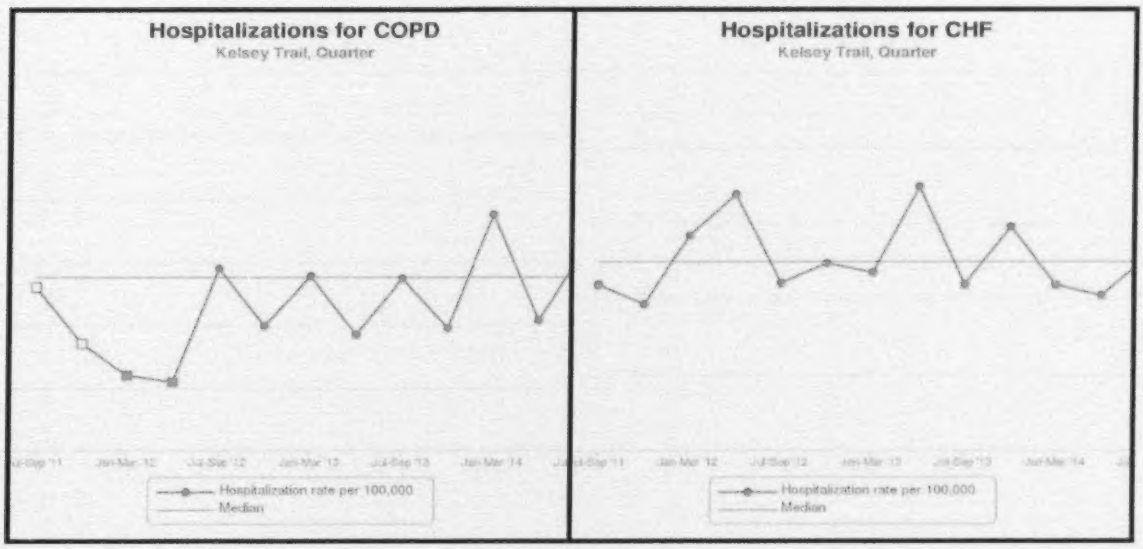
Measurement Results:

Hospitalization rates for six common chronic conditions

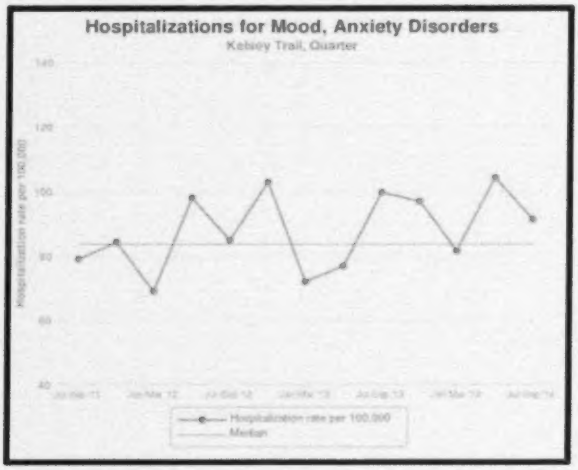
Data for these measures is collected by Health Quality Council through Quality Insight online. Hospitalizations related to Diabetes, Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Coronary Heart Failure (CHF), Depression and Asthma represent an indirect measure of access to primary care and the capacity of the system to manage chronic conditions. Chronic disease related hospitalizations are commonly referred to as avoidable hospitalizations and are therefore considered a measure of the performance of the primary care system. The target for all six chronic conditions is a 30% reduction from baseline of October 2011 by March 2017.

KTHR's interdisciplinary working group on chronic disease management will work on achieving the targeted reduction however, resources are presenting some challenges. Improvement work is currently concentrated on empanelment which is foundational to all of the other work that is necessary to achieve this target. Attaching all patients to a consistent care provider will improve continuity of care which, in turn, is expected to have a positive influence on chronic disease management.





Data points for Asthma hospitalizations from the period October 2012 to September 2014 in KTHR are not enough to provide a chart for this indicator. Data for the remaining chronic conditions is collected quarterly.



Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2020, seniors who require community support can remain at home as long as possible, enabling them to safely progress into other care options as needs change.

Improvement Target
By March 31, 2017, the number of clients with a Method of Assigning Priority Levels (MAPLe) score of three to five living in the community supported by home care will increase by 2%.

Results:

- Demand for home care services in KTHR is directly correlated to the increased medical and psychosocial complexity of clients. In KTHR, 67% of the population receiving home care services represented those over the age of 70 years in 2014-15. The most significant proportion of clients receiving home care services, at almost 32%, is represented by those 80 to 89 years of age, similar to the province.
- At 57.8, KTHR has the highest average home care services per client ratio in the province which allows many clients to remain independent and healthy within their community. KTHR's rate is significantly higher than the provincial average of 45, according to the Ministry of Health Community Care Branch's 2013-2014 Community Program Profile. The region's rate of average home care services per client has decreased by almost 13% over the previous year.
- According to Resource Utilization Groupings (RUGS), at 46% the majority of KTHR home care clients are categorized as reduced physical function. Those categorized as clinically complex are close behind at 28%. RUGS categories reflect resident's level of functioning, care needs and intensity of resource use and are used to determine the resources required in order for them to remain in their home.
- KTHR continues to have the least amount of Personal Care Home (PCH) beds in the province for the population aged 75+ at 6.1 beds per 1,000 people. This is more than seven times less than the provincial average of 45.1 beds per 1,000 people. Within the region, there are only two licensed personal care homes with the capacity to care for a total of 25 clients. This impacts home care utilization for clients that cannot be admitted into long term care. Staff continue to be challenged with increased incidents of behavioural problems, aggression, wound care, palliative care and planning for demanding care.

Measurement Results:

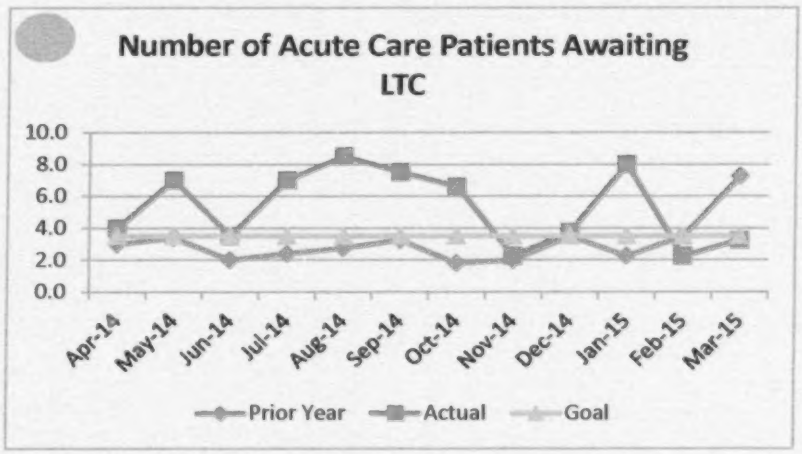
Number of home care patients showing a MAPLe score three to five

Eighty percent of KTHR home care clients are considered Level 3-5 (medium to high priority) according to MAPLe tool evaluation, a decision support tool used to prioritize clients needing community or facility-based services. Clients' assigned very high priority are at higher risk of adverse health outcomes which supports increased home care services and/or priority for

placement if a client cannot be managed at home. At the provincial level, 76% of home care clients fall in the same categories.

	# Home Care Clients	MAPLe				
		1	2	3	4	5
KTHR	754	59	88	183	243	181
SK	13,253	1,708	1,428	3,192	3,952	2,973

Percentage of acute beds occupied by individuals assessed for long term care who are awaiting placement.



Date Prepared: 04/13/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

This number represents the average number of clients waiting for a long-term care placement in acute care beds. In KTHR, acute beds include medical, surgical, pediatric, obstetric, CCU, and other short term acute beds but does not include sub-acute and alternative level of care beds, including observation, respite, long term care, palliative care, rehab and other sub-acute beds. This measure only includes those clients who have been assessed and accepted for long-term care placement. It excludes any other alternate level of care clients who are no longer in need of acute care services, but remain in acute care waiting to be discharged to another appropriate setting.

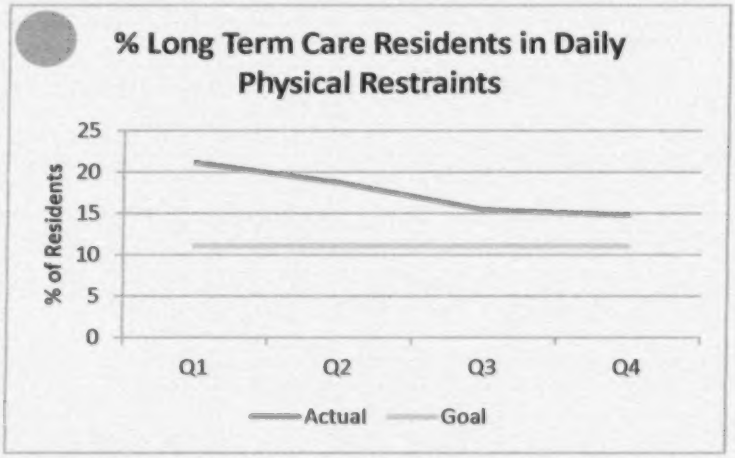
- KTHR successfully achieved a reduction in the average number of clients occupying acute care beds while awaiting long term care placement by March 31, 2015, achieving the target of 3.5%. The region did experience an increase in January with an average of 8 clients awaiting long term care placement. As a result, a corrective action plan was completed with the root cause of the overage directly related to influenza outbreaks experienced in a number of the region's long term care facilities. Transfers from acute care to long term care facilities were delayed until the outbreaks in those facilities were declared over by the Regional Medical Health Officer (MHO) which resulted in a bottleneck that left clients in long term care longer than normal.

- Since 2012-13, the KTHR Access Review Committee (ARC) has addressed clients awaiting long term care placement in acute care beds by immediately placing clients assessed as requiring long term care and receiving extensive care from family/caregivers or family/home care support equal to the home care maximum of approximately 30 hours per week on the transfer list. This allows the client to be supported in home by family with home care "topping up" their care until a long term care bed becomes available.
- KTHR recognizes the potential risk associated with the change in the ARC process is an increased number of individuals on the transfer list.
- Strong emphasis is placed on discharge planning and timely assessments for patients awaiting long term care assessment and placement.
- The number of ALC clients assessed and accepted by the ARC is tracked weekly to ensure clients presented are deemed acceptable for permanent placement.
- Though acute care services and patients are not impacted by the number of individuals waiting for long term care in acute care in the district hospital setting, staff workload is.

Percentage of residents in daily physical restraints

Physical restraint use is one of seven quality indicators the Ministry of Health is monitoring in long term care in 2014-15. Improvement plans are requested from facilities scoring above the national average.

According to the 2013-14 Community Program Profile, the definition of a restraint is any manual method, or any physical or mechanical device, material or equipment attached or adjacent to the person's body that the person cannot remove easily and that restricts the persons' freedom of movement or normal access to his or her body. This includes the use of trunk restraint, limb restraint and chairs that prevent rising.



Date Prepared: 27/04/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Quarterly

In 2013-14, the provincial average for the percentage of residents in daily physical restraints was 14%. KTHR was one of five Regional Health Authorities that was above the provincial average. The Target Value (National Average) for restraint use is 11.10%.

- In February 2015, the region submitted a corrective action plan to reduce restraint use among long term care residents.
  - In long term care settings, many restraints are utilized as positional aids for residents who often cannot support themselves upright while in a chair. Seat or groin belts are considered restraints if residents cannot independently remove them.
  - Pressure exists from families to have their loved ones restrained because some believe restraints will keep them safe and free from injury. Due to the correlation between reduced restraint use and increased falls, it is difficult to convince families and staff of the benefits of not using restraints. Once a resident has become reliant on the safety and comfort they feel, it is difficult to remove a restraint.

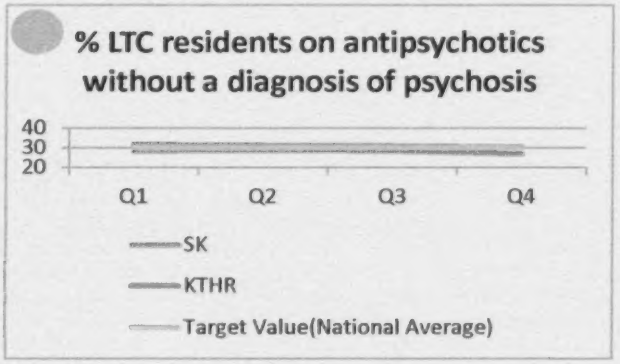
The following measures were implemented as the result of the corrective action plan:

- Beginning February 1, 2015, all KTHR long term care facilities included restraint discussions at huddles and family meetings.
- Beginning March 15, 2015, Occupational Therapy (OT) will provide insight into the use of alternate physical products that are not considered restraints where applicable and available.
- Intentional (Purposeful) Rounding was initiated in Hudson Bay. Initial work toward implementation in all long term care facilities in the region will start in 2015-16 with a goal to achieve full implementation in at least three facilities.
- By March 31, 2015, facilities will follow-up with families and the physician of residents currently in restraints to review the possibility of decreasing or eliminating the use of restraints.
- Beginning February 1, 2015, Facility Administrators will work with the MDS Coordinator to provide Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs) with updated education on restraint coding for MDS.

Percentage of residents on antipsychotics without a diagnosis of psychosis

KTHR reported an average of 28.17% for this quality indicator in 2014-15, which is less than the provincial average of 31.21% as well as the Target Value (National Average) of 30.80%, according to the 2013-14 Community Profile Program. This quality indicator is considered a quality of life issue for residents living in long term care facilities.

Overall, the region recorded a slight decline in the percentage of residents on antipsychotics without a diagnosis of psychosis during the 2014-15 fiscal year, moving from a high of 28.39% in the first quarter to 26.96% in the fourth quarter.



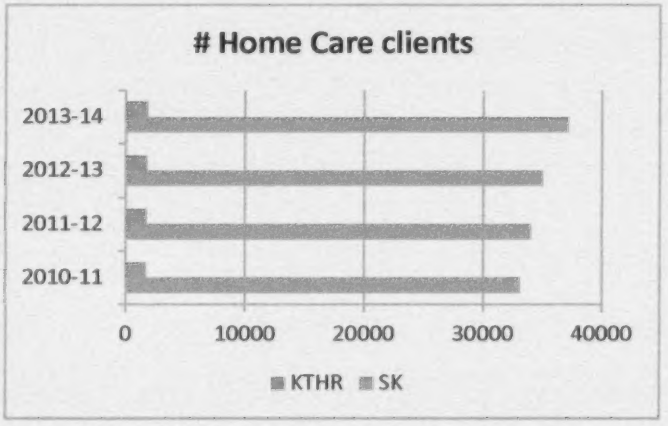
Date Prepared: 27/04/2015
Report Contact: Deb Atkings, MDS Coordinator
Refresh Cycle: Quarterly

The following measures were implemented:

- ongoing continuing education for all nursing staff on antipsychotic use and alternatives;
- monthly quality improvement checks to catch MDS coding errors, discuss them with staff and fix them prior to locking; and
- reviewing all current lists of residents on antipsychotics and having discussions about antipsychotic use with physicians and pharmacists on a regular basis at subsequent reviews to ensure care plans are up-to-date.

Number of Home Care clients

KTHR's home care client numbers have increased slightly over the past four years, similar to the province. According to the 2013-14 Community Profile Program, between 2010-11 and 2013-14 KTHR has reported an 8.4% increase in home care clients as compared to an 11.63% increase in the number of home care clients provincially over the same period. KTHR data indicates there was a slight two percent decrease in home care clients in 2014-15.



Source: 2013-14 Community Program Profile, Community Care Branch, Ministry of Health

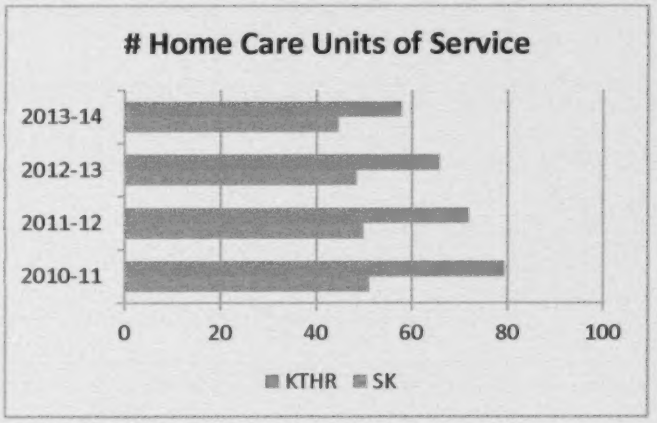
Over the years, there has been an increase in acute care home care services, including facilitating early hospital discharges and preventing hospital admissions, increasing community-based palliative care services to allow clients to die at home with dignity, increasing support to reduce admission to long-term care and provide respite to the client's supporters, and

increased home care and rehab supports post-surgery in support of the Saskatchewan Surgical initiative.

Number of home care units of service

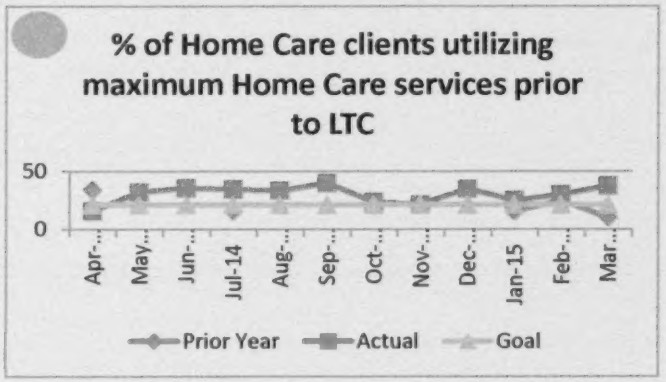
A unit of service is one meal or one hour of service in the client's home. Although the number of home care units of service per client in KTHR and the province has steadily declined since 2010-11, KTHR has the highest average home care services for clients in the province, not including the three northern health regions.

In 2013-14, the province averaged 45 units of service per client while KTHR averaged 57.8. The majority of home care units of service in KTHR, like the province, are in homemaking followed by meals and nursing.



Source: 2013-14 Community Program Profile, Community Care Branch, Ministry of Health

KTHR is measuring the percentage of home care clients utilizing maximum home care services prior to long term care. Individuals desiring long term care are required to be at a higher level of care as indicated by MAPLe scores.



Date Prepared: 04/13/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

KTHR long term care has housed clients that could be cared for at home with additional community resources for staff and funding. Providing support to individuals to remain at home delays institutionalization. If appropriate services/supports are not available to clients and their caregivers, these individuals may be at risk for admission into acute care and/or long-term care which may also affect the quality of life for individuals no longer at home. This increases the burden on the health care system and the cost of care, which is higher in institutions than at home.

Better Health

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2019, there will be increased access to quality mental health and addiction services and reduced wait time for outpatient and psychiatry services.

Improvement Target
By March 31, 2017, wait time benchmarks for mental health and addictions will be met 100% of the time.

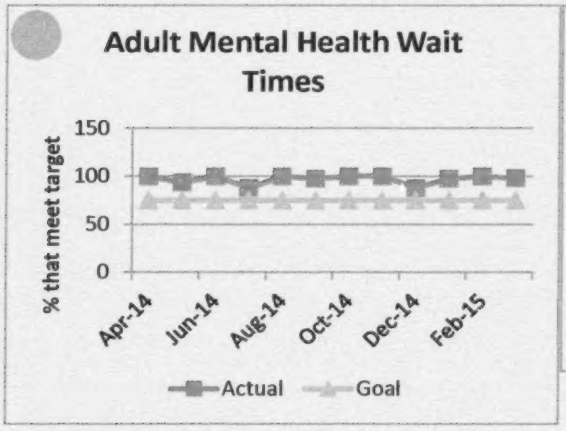
Results:

- In October 2014, KTHR participated in an RPIW focused on reducing the wait time for level 3 and 4 initial appointments with Mental Health & Addiction Services clinicians, improving patient flow and responsiveness to patient needs.
- The previous method of scheduling new appointments (two time slots per week per clinician) was causing unnecessary delays for first appointments for patients.
    - 11 out of 90 Level 3 patients waited 16 days or more (12%)
    - 60 out of 132 Level 4 patients waited 16 days or more (45.5%)
- Although the previous wait times met the provincial standard for first appointment, they were not responsive to patient needs or conducive to effective therapies. All level 3 and 4 clients should have their first appointment in less than 15 days.
- At first appointment, the provider develops a plan of treatment for the client. When the actual course of treatment exceeds this plan, there is no standard approach among providers on how to conclude treatment or escalate care. In some cases, a client may remain on the caseload even when no specific care plan is being followed.

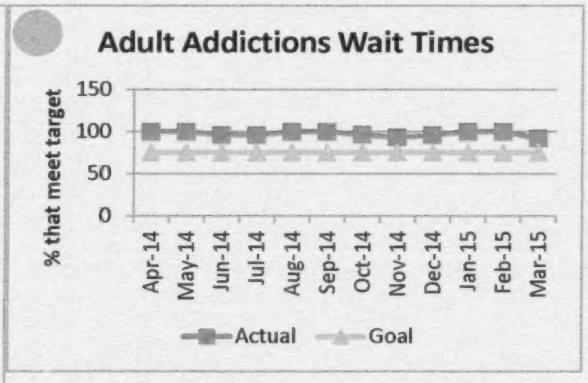
Through the improvement work accomplished during the RPIW, the lead time from referral received at Mental Health & Addiction Services to first appointment with a clinician was reduced. This was accomplished through the implementation of several changes:

- new clients are booked for the first available appointment with the appropriate clinician;
- just-in-time service is provided by placing a mental health clinician in the physician clinic; and

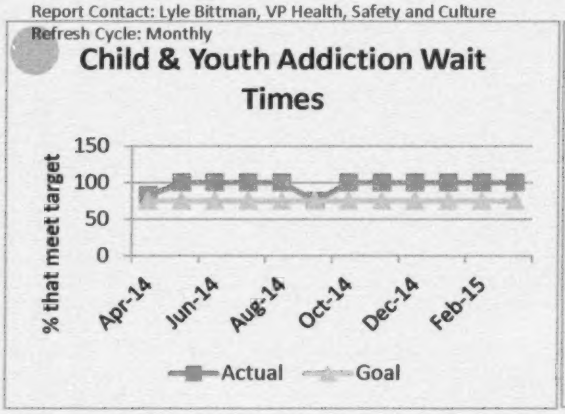
- time and steps in the intake process are reduced through e-fax.



Date Prepared: 04/20/2015
Report Contact: Lyle Bittman, VP Health, Safety and Culture
Refresh Cycle: Monthly



Date Prepared: 04/20/2015
Report Contact: Lyle Bittman, VP Health, Safety and Culture
Refresh Cycle: Monthly



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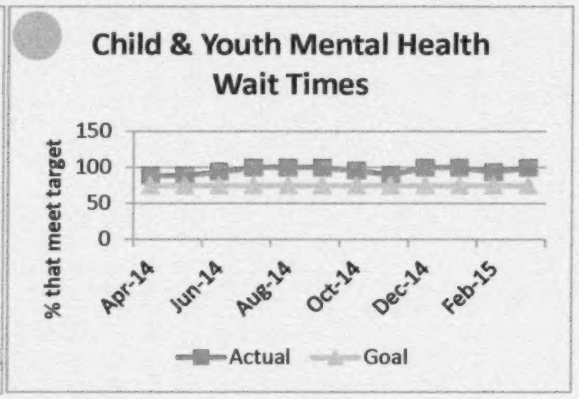
Refresh Cycle: Monthly



Date Prepared: 04/20/2015
Report Contact: Lyle Bittman, VP Health, Safety and Culture
Refresh Cycle: Monthly

New clients to Mental Health and Addictions have quicker access to service by being offered the first available appointment despite their triage level. There is better continuity and less opportunity for mistakes in the intake process with electronic faxing.

Level 3 and 4 client wait times were reduced through the implementation of first available appointments and the location of clinicians in the medical clinic, ensuring access to and the availability of the right provider at the right place at the right time. Standard work was developed to assist with communication and the e-fax was implemented to save steps, time and reduce errors. A production control number was developed to help management and staff gain a clearer understanding of the health of the intake system.

Through the RPIW, the lead time for Level 3 clients was reduced by 42% while the lead time for Level 4 clients was reduced by 92%. In addition, all Level 3 and 4 clients received appointments within 15 working days. The assessor coordinator's capacity increased by 56 percent, reducing intake completion from 28:30 to 18:34 minutes.

Thirty, 60, 90 and 180 day audits indicate the team has been unable to sustain the goal to schedule Level 3 and 4 clients within 15 days from assessment to first offered appointment. As a result, standard work was updated. Weekly audit reports are now provided to the Manager, Director and Vice President. Staffing levels have been stabilized for the department and the RPIW Audit process will be re-set in an attempt to address the barriers to achieving the target.

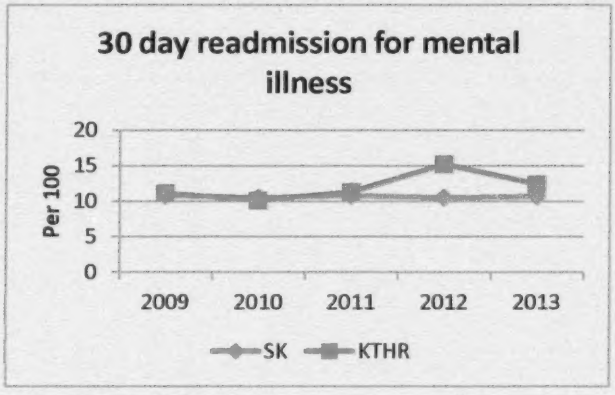
Measurement Results:

Percentage of Mental Health and Addictions clients meeting the wait time benchmarks based on triage level. (*Target for all triage levels is 70% in 2014-15*).

Wait time benchmarks are as follows: Very Severe (Level 1) – 24 hours; Severe (Level 2) – 5 working days; (Level 3) Moderate – 20 working days; (Level 4) Mild – 30 working days. KTHR is meeting wait time targets for all four Levels.

Number of individuals readmitted within 30 days to mental health inpatient units

According to the Canadian Institute for Health Information (CIHC), KTHR's 30 day readmission for mental illness is higher than both the provincial and national rate at 12.4 per 100 in 2013. The national rate of 11.5 per 100 is slightly higher than the provincial rate of 10.7.



Date Prepared: 05/25/2015
Health Indicators Interactive Tool, 1996-2014, Canadian Institute for Health Information (CIHI)

This indicator measures the risk-adjusted rate of readmission following discharge for a mental illness such as substance-related disorders; schizophrenia, delusional and non-organic psychotic disorders; mood/affective disorders; anxiety disorders; and selected disorders of adult personality and behaviour.

Readmission to inpatient care may be an indicator of relapse or complications after an inpatient stay. Inpatient care for a person living with a mental illness aims to stabilize acute symptoms. Once stabilized, the individual is discharged, and subsequent care and support are ideally

provided through outpatient and community programs in order to prevent relapse or complications. High rates of 30-day readmission could be interpreted as a direct outcome of poor coordination of services and/or an indirect outcome of poor continuity of services after discharge.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2019, there will be a 50% decrease in wait time for appropriate referral from primary care provider to all specialists or diagnostics.

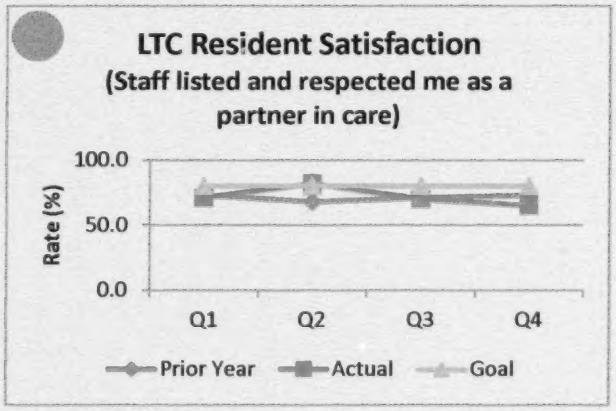
Measurement Results:

Surgical wait times for each of the pilot clinical areas

In 2014-15, KTHR maintained the previous year's target for all patients to have the option to receive necessary surgery within three months. At the conclusion of the four-year Saskatchewan Surgical Initiative (SSI) on March 31, 2014, KTHR was one of four health regions in the province to achieve the three month wait time target. Of the 10 health regions that provide surgical services, KTHR was one of seven with zero patients waiting more than three months as of March 31, 2015.

Patient experience collected from patient surveys

Health Quality Council (HQC) discontinued reporting Patient Experience Survey data in March 2014 in response to feedback regarding other potential approaches to patient surveying that would better meet RHA needs. An advisory group has been formed to explore options for obtaining feedback from patients about their acute care experiences however a process for collecting this feedback has not been developed or implemented to date.

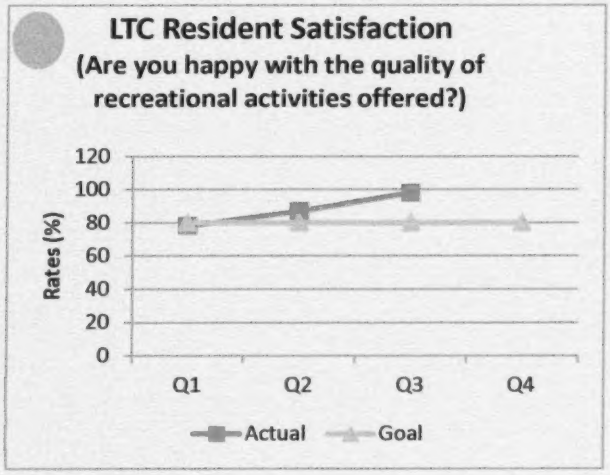


Date Prepared: 04/27/2015

In KTHR, client experience surveys have been implemented in other service areas including long term care and, more recently, home care. Surveys are

distributed on a quarterly basis.

The target for client satisfaction surveys is to achieve 85% or greater satisfaction. After exceeding the target in Q2, Quarter 3 (October 1-December 31) and Q4 (January 1 – March 31) long term care survey results demonstrated a decline in overall resident satisfaction with regards to communication efforts between staff and clients. Specifically, responses to: "Staff listened and respected me as a partner in care" and "my treatment was explained fully, clearly in a useful way" dropped to 79% and 67% respectively. Staff strive to be partners in care with the residents and want to ensure effective communication occurs consistently and respectfully.



Date Prepared: 04/27/2015

A corrective action plan was developed in March 2015. Root cause analysis revealed:

- Staff care for multiple resident needs during a shift. Verbal and non-verbal cues may demonstrate to residents that staff are rushed and do not have time to fully listen to the residents or explain care provisions.
- Care provision is "routine" for care providers who may assume that residents are also aware of the routine. Different care providers will perform care in different ways therefore it is important to explain the care routine to residents.
- Physicians and nurses communicate treatments differently which may be perceived by residents as confusing or not occurring due to alter perception or recollection of conversation as the result of health issues.
- There are often a low number of respondents to the long term care surveys which results in potentially skewed results.

The corrective action plan resulted in a number of improvement initiatives:

- Resident Rights & Responsibilities are reviewed to ensure clear understanding of service provision to residents.
- Resident-centred language review was initiated three days a week to create full awareness the language spoken with/to/about residents is respectful and appropriate.
- Staff documentation with treatment explanations and reminders in communication books.

KTHR received $250,000 in funding through the Urgent Issues Action Fund. The fund was created in 2013 to provide $10.4 million to assist health regions in addressing priority issues. An additional $3.8 million was provided to manage ongoing pressures. The region used the funding it received to provide recreational activities on evenings and weekends in long term care. Previously, activities only took place during the daytime Monday through Friday. The addition of weekend and evening activities has had a positive impact on response to the survey question "Are you happy with the quality of recreational activities offered?". Since the survey started, this measure has consistently met and exceeded the 80% target. Data for Q4 was unavailable.

Better Care

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2017, no patient will wait for care in the Emergency Department (ED).

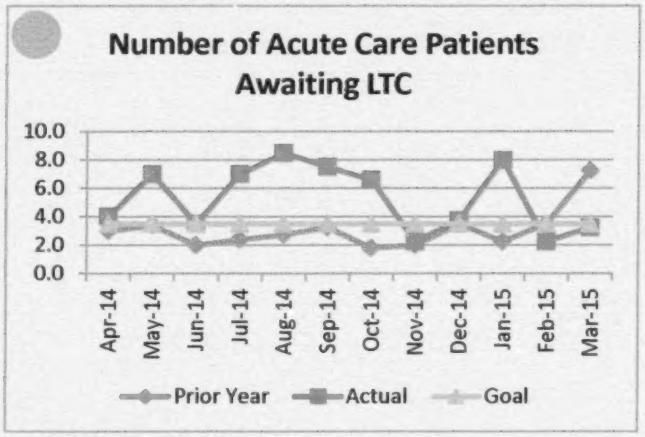
Provincial Hoshin: At least 85% of patients requiring admission from emergency department are admitted to an appropriate bed within 5 hours.

Improvement Target

Maintain the number of Alternate Level of Care days (waiting placement) across the province and in each region at no more than 3.5% of total.

Results:

KTHR successfully achieved a reduction in the average number of clients occupying acute care beds while awaiting long term care placement by March 31, 2015, achieving the target of 3.5%. The region did experience an increase in January with an average of 8 clients awaiting long term care placement. As a result, a corrective action plan was completed with the root cause of the overage directly related to influenza outbreaks experienced in a number of the region's long term care facilities. Transfers from acute care to long term care



Date Prepared: 04/13/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

facilities were delayed until the outbreaks in those facilities were declared over by the Regional Medical Health Officer (MHO) which resulted in a bottleneck that left clients in long term care longer than normal.

The number of acute care beds occupied by residents waiting for LTC placement exceeded the target of 3.5% in July (6.25%), August (6.8%), September (6.7%) and October (5.9%). It declined in November (2.0%) and December (3.75%) before increasing again in January (7.1%).

In 2014-15, the majority of clients were placed in long term care from hospital. Thirty percent of clients maximized home care prior to presentation to long term care.

Root cause analysis also determined several other factors that contributed to the challenges associated with achieving this measure:

- Home care services are available less frequently in the smaller, rural communities.
- There has been inappropriate or premature categorization of clients to long term care.
- The only assisted living services provided within the region are located in Melfort.

In the coming fiscal year, healthcare professionals in KTHR will maintain the Alternate Level of Care (ALC) days at no more than 3.5% through exploration of Home First principles for all potential ALC clients. In addition, the regional physician group will be involved through the re-evaluation of the grand rounds routine.

Measurement Results:

Number of ALC days as a proportion of total Acute Care bed days

According to 2014-15 acute care data from the CIHI Discharge Abstract Database (DAD), the number of ALC days as a proportion of total acute care bed days in KTHR is 6.5%. KTHR acute care data from the CIHI DAD for 2014-15 is only available up to January 2015. DAD for February and March 2015 is incomplete.

According to an Analysis in Brief on "Alternate Level of Care in Canada" released by CIHI in January 2009, ALC patients accounted for 5% of hospitalizations and 14% of hospital dates in acute care facilities in 2007-08 (excluding obstetric and pediatric patients). Of the provinces included in the analysis, Saskatchewan and Prince Edward Island had the lowest ALC rate at that time at 2%. According to "Health Care in Canada, 2012: A Focus on Wait Times" released by CIHI in 2012 and including data up to 2010-11, the Canadian ALC rate has remained stabled since 2009-09 at approximately 5%.

Due to concerns with the consistency with which clients are ALC, the point in the hospital stay when ALC diagnosis is coded, and variation among acute care facilities on the proportions of ALC hospitalizations and stays, CIHI does not regularly use the ALC measure for comparative reporting.

Acute Care 30 and 60 day Readmission Rates

According to CIHI, this indicator measures the risk-adjusted rate of urgent readmissions within 30 days of discharge for episodes of care for the following patient groups: obstetric, patients age 19 and younger, surgical and medical. Readmission rates can be influenced by a variety of factors, including the quality of inpatient and outpatient care, the effectiveness of the care transition and coordination, and the availability and use of effective disease management community-based programs. While not all unplanned readmissions are avoidable, interventions during and after a hospitalization can be effective in reducing readmission rates. Lower readmission rates are desirable.

The KTHR acute care 30 day readmission rate for 2014-15 is 8.9%. The 60 day readmission rate is 16.1%.

Better Value	**The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2017, as part of a multi-year budget strategy, the health system will bend the cost curve by lowering status quo growth by 1.5% per year.**

Improvement Target
By March 31, 2015, shared services will achieve measurable improvements in quality while achieving the $100M in cumulative savings.

Results:

In 2014-15, 3sHealth developed five values that guide our work, priorities, and interactions with clients and stakeholders. They are:

- Collaboration
- Innovation
- Integrity and trust
- Transparency
- Bold and courageous leadership

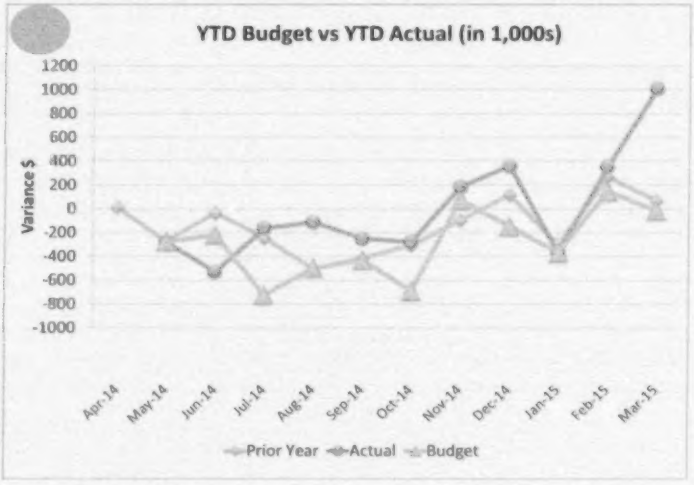
In alignment with those values and together with the health regions and SCA, 3sHealth celebrated the following key achievements in 2014-15:

- Surpassed its five-year cost savings goal of $100 million for the healthcare system, saving over $110 million through collaboration and innovation in provincial contracting, linen savings, and other initiatives.
- Completed, in partnership with Regina Qu'Appelle Health Region and Wascana Rehabilitation Centre, a lean replication event that improved linen handling and inventory management in long-term care units.
- Worked with provincial contracting partners to create a product issue reporting process, ensuring safe, high-quality products are available for patient care across the healthcare system.
- Explored improvement opportunities in areas such as transcription services, the provincial supply chain, environmental services, medical laboratory services, medical imaging services, enterprise resource management, and enterprise risk management, focusing on the ways the system can work together to implement solutions that improve care for patients and their families.

Measurement Results:

2014-15 Regional Health Authority and Athabasca Health Authority financial status, as measured by operating surplus/deficit.

In 2014-15, KTHR achieved an operating surplus of $912,212 after mortgages and transfers, exceeding the budgeted surplus of $5,355. The KTRHA approved the transfer of a capital allocation of $684,159, leaving a surplus of $228, 053 for the fiscal year.



Date Prepared: 04/27/2015
Report Contact: Connie Glaves, VP Corporate Services
Refresh Cycle: Monthly

The region was able to achieve a balanced budget in 2014-15 due to several factors:

- $1.9 million in savings due to vacancies;
- $220,000 savings as the result of administrative restructuring; and

- $400,000 in supply cost savings.

The region's efficiency targets were set at $1.543M with savings expected to be generated in the areas of:

- Service delivery/Shared Services – savings through shared services initiatives led by 3sHealth
- Compensation – workforce optimization, attendance management, strategic partnerships and service alignment; and
- Variation and Appropriateness – addressing unwarranted variation in care and inappropriate care.

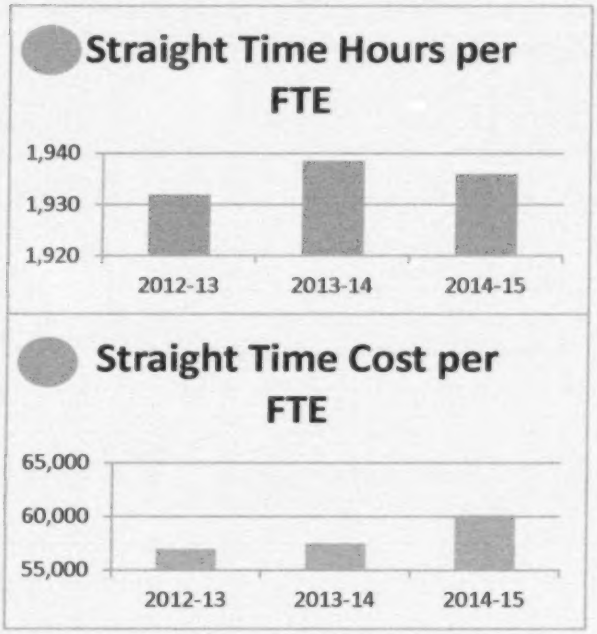
Improvement Target
By March 31, 2015, we will have spent 1% less on straight time worked hours and premium hours than in 2013-14, resulting in approximately $20M savings to the system.

Results

Straight time and premium costs
Straight time and premium hours

Straight time includes regular time, orientation, vacation, all Leaves of Absence (LOAs) and statutory holidays. KTHR did not meet the target of 1.1% reduction in either straight time hours or straight time costs.

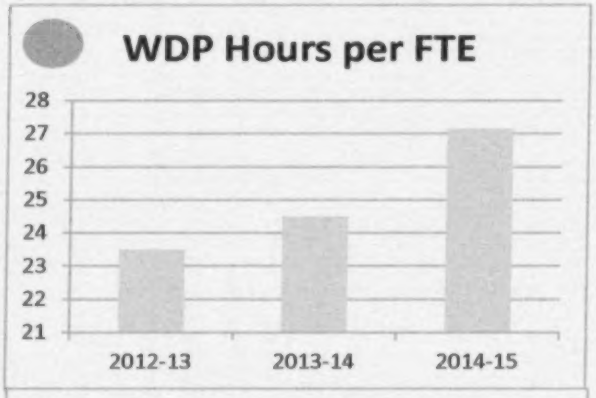
In KTHR, straight time hours per FTE decreased by 0.14% over the previous fiscal year. KTHR recorded 1,935.96 straight time hours in 2014-15 as compared to 1,938.60 the previous year. At, $60,103.04, the region's straight time cost per FTE increased by 4.62% over the previous year. Straight time costs per FTE were $57,447.25 in 2013-14.

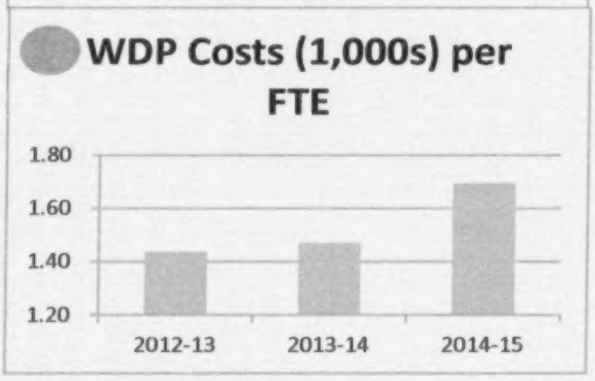


Date Prepared: 06/01/2015
Report Contact: Connie Glaves, VP Corporate Services
Refresh Cycle: Annually

KTHR did not meet the targeted reduction in Wage Driven Premium (WDP) hours or costs per FTE this year. WDP hours include overtime and callback.

This year's target was 17.17 WDP hours per FTE. At 27.15 per FTE, KTHR's WDP hours remain significantly lower than the provincial rate of 43.84 and are the second lowest in the province. The region's WDP hours per FTE increased by 10.87% in 2014-15 in comparison to the previous year. There was a 15.22% increase in WDP costs per FTE in 2014-15.





Date Prepared: 06/01/2015
Report Contact: Connie Glaves, VP Corporate Services
Refresh Cycle: Annually

KTHR was assigned attendance management and workforce optimization targets of $659,000 in 2014-15. Workforce optimization is defined as staffing areas to meet actual demand with the right service. Some of this work started during the previous fiscal year with work done on baseline staffing.

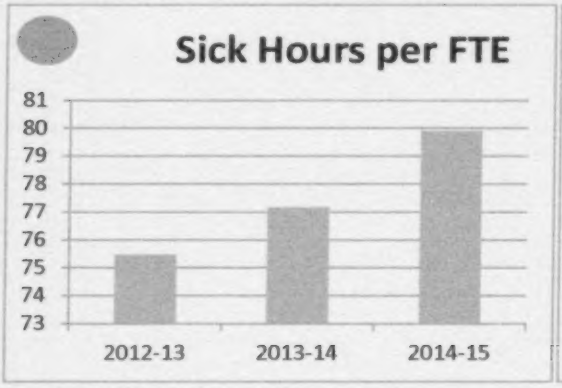
Facility-level action plans are being used to address WDP hours, including root cause analysis and changing culture. Focused attention on sick time and overtime data at visibility walls in facilities and departments has increased awareness of the attention required to manage and decrease these areas. Managers are required to submit monthly variance reports and work on baseline staffing continues. Through creating awareness and offering tools to managers, this collaborative and supportive approach will be critical to gaining an understanding of current state. The continued work of the Regional Attendance and Disability Support Coordinator is directed at high sick time users. In an effort to reduce overtime costs, KTHR is focusing on overtime authorization and standard work.

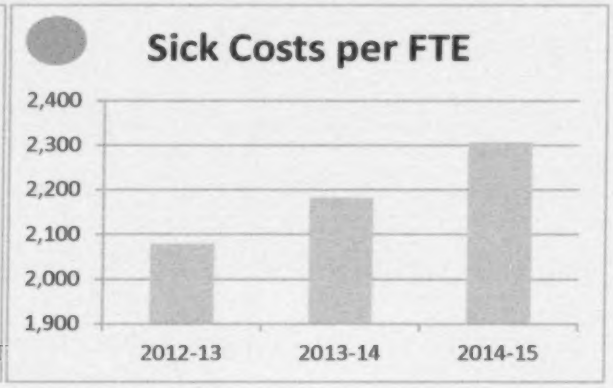
Overtime hours tend to increase during periods of peak utilization and often correlate with sick time. Overtime hours are also associated with staffing shortages in hard-to-recruit areas such as Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Continuing Care Aides (CCAs).

Sick time costs
Sick time hours

Sick time hours continue to be a concern for KTHR. In 2014-15, the region's sick time hours per paid full-time equivalent (FTE) were higher than the previous year. KTHR recorded 79.91 sick

time hours per FTE in 2014-15, an increase of 3.55% over the previous year. Provincially, KTHR was slightly higher than the provincial average of 79.86 hours per FTE and has the sixth lowest sick time hours among the 12 health regions.





Date Prepared: 06/01/2015
Report Contact: Connie Glaves, VP Corporate Services
Refresh Cycle: Annually

Sick costs per FTE also increased in 2014-15 as compared to the previous year, rising by 5.70% to $2,307.13. In 2013-14, sick costs were 2,182.74 per FTE.

The increase in regional sick time hours in 2014-15 was influenced by a number of outbreaks that resulted from Influenza A – H3N2, a drift in the circulating strain of influenza that made the influenza vaccine less effective. A significant number of maternity leaves and the resulting increase in pregnancy-related illness, KTHR's aging workforce and a suspected decline in physical fitness and endurance levels are also contributing factors. A shortage of staff in hard-to-recruit areas is also a contributing factor.

Better Value

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome that by March 31, 2017, all infrastructure (information technology, equipment and facilities) will integrate with provincial strategic priorities, to be delivered within a provincial plan and adhere to provincial standard work.

Improvement Target
By March 31, 2015, equipment and facility renewal planning processes will be developed to ensure a coordinated and integrated provincial approach

Results:

- KTHR received one-time funding in the amount of $225,000 to help address the need for diagnostic, medical, surgical, patient comfort/safety equipment and IT equipment in the 2014-15 fiscal year. A minimum of 30% ($67,500) was to be spent on equipment in long term care facilities.
- Block funding in the amount of $527,500 was also received and earmarked to address Life Safety/Emergency & Infrastructure projects.
- In December 2014, the KTRHA approved the KTHR Digital Imaging Plan. With the support of community trusts and foundations, the existing Computed Radiography (CR) technology will be replaced with Digital Radiography (DR) technology in all six acute care sites as well as Carrot River Health Centre.
- The Panorama Inventory (introduced in February 2014) and Panorama Immunization (introduced in September 2014) were deployed provincially this fiscal year. Saskatchewan patients and health providers are now benefitting from a new, electronic integrated public health information system. "Panorama" allows public health care providers to manage vaccine inventories and immunizations, and enhances their ability to deliver services to residents.
- KTHR Public health completed training on the new Hedgerow software program which was implemented March 18, 2015. The program allows inspectors to use tablets in the field to complete inspections and issue licenses on the spot.
- KTHR negotiated cost efficient replacement of the CVA fleet with ARI to provide better quality and safer vehicles.

Better Teams

The Kelsey Trail Regional Health Authority supports the provincial health system's five-year improvement outcome to achieve a culture of safety, by March 31, 2020 there will be no harm to patients or staff.

Improvement Target

By March 31, 2017, fully implement a provincial Safety Alert/Stop the Line System.

Results:

- Improving the safety of patients and healthcare workers is a top priority in Saskatchewan. The Saskatchewan Healthcare Management System Plan for 2014-15 includes a section on Culture of Safety under the Better Teams Strategy. A key action

item to improve the Culture of Safety in our province is to "begin implementation of a provincial Safety Alert System and Stop the Line process" that will eliminate harm to both the patients we serve and those providing care.

- Improving the safety of patients and healthcare workers is a top priority in Saskatchewan. Each day, patients, clients, residents, staff and physicians experience defects in the health system. While harm can occur in all healthcare settings, many of these harms are preventable when a strong safety culture exists and safety practices are embedded in daily work.
- Design and implementation of a Safety Alert System (SAS) supports the detection of safety issues, encourages the reporting of events, and the prevention of errors in healthcare settings by empowering patients, families and healthcare workers to recognize a potentially dangerous situation and trigger a process to stop the harm before it occurs (Stop the Line (STL)). Reported incidents are then reviewed and improvements implemented to reduce future harm and defects.
- The current state of safety and adverse event reporting systems varies widely and has not been standardized across the province. Each health region and organization utilizes a separate region or organization-specific system to report these events. A provincial working group is coordinating efforts with all health regions regarding Safety Alert System/Stop The Line processes.

Measurement Results:

Level of readiness for provincial Safety Alert/Stop the Line in each health region

During the 2014-15 fiscal year, KTHR focused on evaluating the current state of the region's Safety Management System and ensuring the implementation of the required elements. This year, implementation was focused on:

- Element 1 – Management and Leadership
- Element 2 – Hazard Identification and Control
- Element 3 – Training and Communications

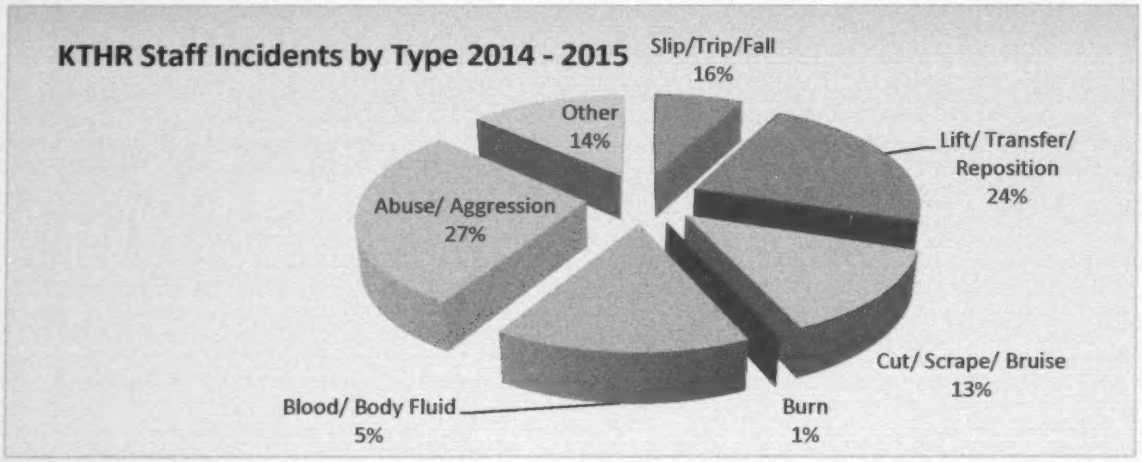
In the coming fiscal year, KTHR will continue to ensure regional implementation of the next three elements of the Safety Management System while sustaining elements already in place. Implementation of the next three elements will include:

- Element 4 - Inspections
- Element 5 – Reporting and Investigations

- Investigation of all lost time claims to root cause
- Campaign to raise awareness regarding the link between identifying root cause and injury prevention
- Regional Health and Safety support to managers, supervisors and front line staff in their efforts to acquire knowledge and skills in hazard identification and root cause investigation

- Element 6 – Emergency Response

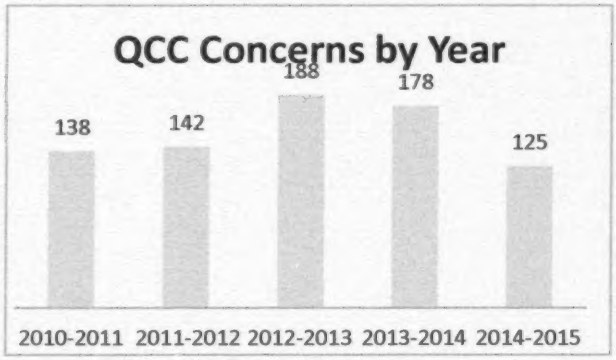
Number of incidents reported by staff, and by patients and family members



Report Contact: Joanne Penner, KTHR Regional Safety Officer
Refresh Cycle: Annually

At 381 incidents, KTHR staff reported one less incident in 2014-15 than the previous year. In 2014-15, over half of the incidents reported were due to abuse/aggression (27%) and transfer/lift/repositioning (24%). In the previous year, transfer/lift/repositioning and slip/trip/fall were the two highest reported incidents among staff. Incidents of abuse/aggression have increased by seven percent from 2013-14 to 2014-15.

All concerns reported directly to the KTHR Quality of Care Coordinator are entered into the Client Concern Handling System (CCHS). This information is used for the Client Concern Handling System Annual Report by the Ministry of Health.

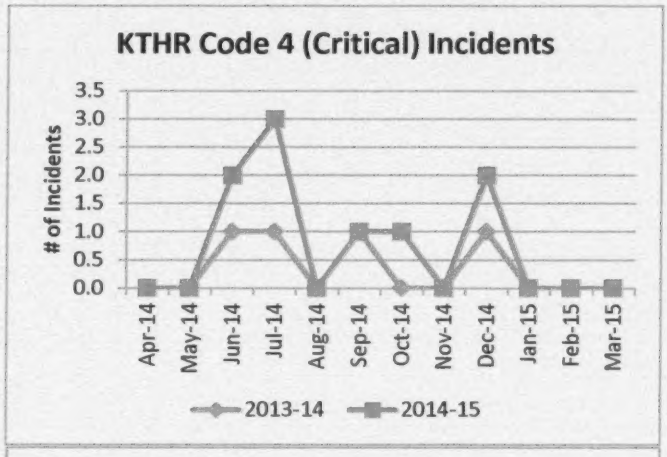


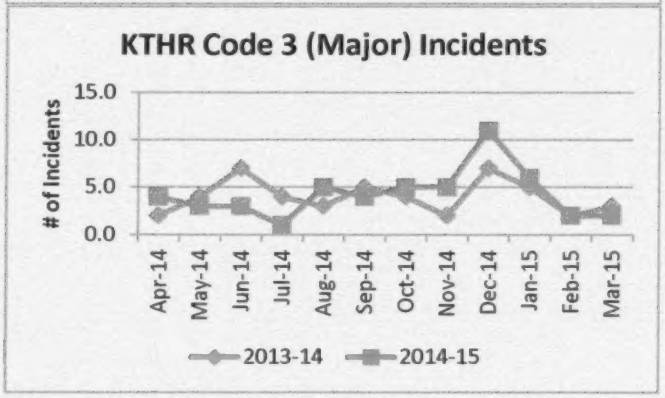
Report Contact: Avalene Soulier, QCC/Kaizen Specialist
Refresh Cycle: Annually

All concerns are dealt with nearest to the source of the concern and follow-up is made with clients when possible or appropriate. The total concerns reported by clients have decreased by almost 35% in 2014-15 as compared to the previous fiscal year. The number of client concerns has been gradually declining over the past three years.

Number of incidents investigated for root cause, with implementation of a corrective action plan.

All critical (Level 4) incidents include an extensive incident analysis and development of an action plan. Critical incidents are defined as "a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service provided by, or a program operated by, a regional health authority (RHA) or health care organization (HCO)." The KTHR Quality of Care Coordinator is responsible for identifying events where a patient is harmed (or where there is a potential for harm), reviewing and conducting an investigation into the incident and implementing necessary changes within the region that are reviewed and may be implemented provincially.





Date Prepared: 09/10/2014
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

While relatively low, KTHR reported a total of five critical incidents in 2014-15, one more than the previous fiscal year. The reporting of any critical incidents is a concern given the ultimate goal to have no incidents that do or have the potential to harm patients.

Of the five critical incidents reported during the fiscal year, five of the twelve recommendations resulting from incident analysis remain open, requiring additional time for policy development and approval prior to implementation.

Fifty-one major (Code 3) patient incidents were reported during the 2014-15 fiscal year. This is a slight increase over the 48 recorded the previous year.

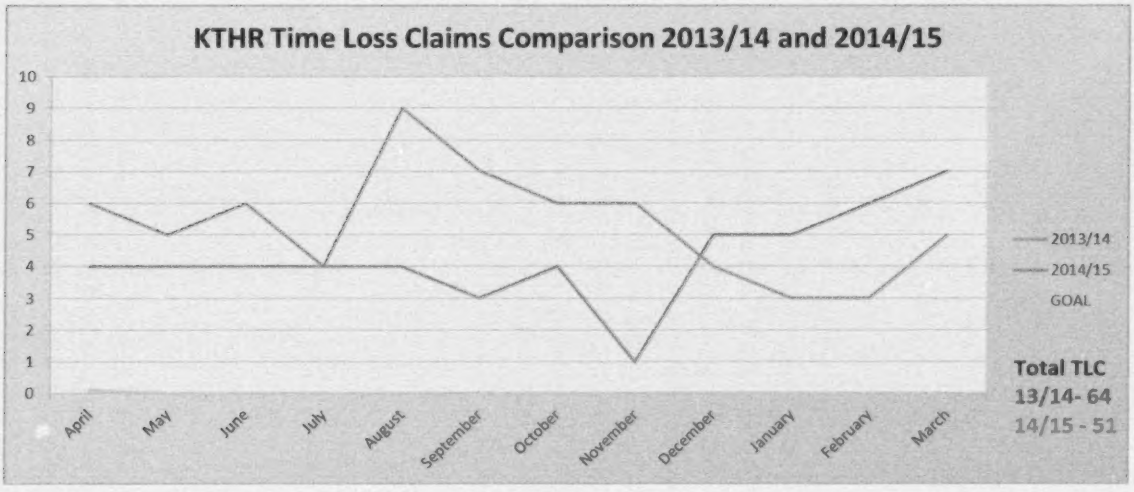
Time from incident to implementation of corrective action plan

KTHR began tracking this measure in January 2015. The time from incidence occurrence to the implementation of corrective action plans varies considerably however immediate action is always taken until incident analysis can be completed. The time between incidents occurring and the implementation of corrective action plans varied from zero to 35 days, with the majority either zero or one day.

The outcome of incident analysis may result in several recommendations. In 2014-15, the total number of recommendations resulting from incident analysis ranged from a low of zero to a high of eight per incident. The implementation of those recommendations may occur over several months, depending on the nature of the incident as well as the number of recommendations that resulted from incident analysis.

Improvement Target
By March 31, 2016, there will be zero shoulder and back injuries.

Results:



Report Contact: Joanne Penner, KTHR Regional Safety Officer
Refresh Cycle: Monthly

At the start of 2014-15 fiscal year, Kelsey Trail Health Region had a goal to decrease time loss injuries sustained by employees. This has been achieved with 13 less time loss injuries occurring in 2014 – 2015 on comparison to the previous fiscal year. This amounts to a 20% reduction in injuries that required employees to miss at least two days of work.

There is no single explanation for the successful reduction KTHR recorded this year. The region has systematically worked toward changing the approach to safety, moving from a mindset of meeting safety requirements to one where performing work safely is the goal.

Intentionally shifting thinking away from seeing safety as a list of requirements that must be met to performing work safely resulted in the implementation of the following initiatives:

- Re-introduction of the Regional Occupational Health & Safety Advisory Committee
- Ensuring OHC members received their Level 1 & 2 OHC training
- Development of KTHR-specific Safety for Supervisors training
- Time Loss Notices to Manager, Director and VP of injured employee
    - Increased awareness resulting in attention to investigation and follow-up
- Implementation of Injury Alert Line
    - Responding in a timely manner to prevent or reduce time lost
    - Increased attention to incidents and injury
- Safety Talks at daily huddles with frontline staff in KTHR facilities
- Updated OH&S Incident Report form
- Increased safety focus at Manager meetings
- Enhanced orientation of new hires
    - Set clear expectations of working safely as a condition of employment
    - Increased discussion on responsibility, reporting and reducing injuries
- Increased capacity in through hiring of a second Disability and Attendance Management position and a Regional Safety Officer
- Work with WCB/Attendance to better manager injuries and reduce time lost
- Improved TLR Regional Mentorship Strategy
- Performance Management & Discipline for non-compliance with safety expectations

The implementation of visibility walls in all KTHR facilities has increased awareness and communication regarding regional safety strategies, initiatives and targets. Daily visual management boards and huddles have also improved communication and provided opportunities for workers and managers to discuss all areas of work, including safety.

Measurement Results:

Number of accepted WCB shoulder and back injury claims

Shoulder and back injuries accounted for 51% of KTHR employee's time loss injuries in the fiscal year 2014-15. This chart details the number of should and back claims accepted by the Worker's Compensation Board (WCB) for KTHR for the 2013-14 and 2014-15 fiscal years. As of

March 31, 2015 KTHR's shoulder and back claims were at 26, a reduction of six, or 19%, from the previous year. The provincial target for a 50% reduction in shoulder and back claims among all health regions was not met. As of March 15, 2015, the provincial reduction in shoulder and back claims was less than one percent.

Although the region did not meet the 50% targeted reduction in shoulder and back claims, KTHR is well above the provincial average and headed in the right direction with the 19% reduction achieved in 2014-15.

In KTHR, the majority of injuries are occurring while employees are transferring, lifting or repositioning clients. The second highest cause of injury is related to slips, trips and falls. Reducing shoulder and back injuries will continue to be a focus within the region in the new fiscal year with the provincial target set at a 50% reduction.

Several strategies will be used to focus on sustaining successes in injury reductions KTHR has achieved in 2014-15 including:

- Continuing to ensure all required elements of the SMS (Safety Management System) are implemented or in place. Priority areas will include inspections, investigations and emergency response.
- Facilitating Root Cause and Analysis training to assist in completing investigations and achieving remedial actions.
- Analyzing any noticeable injury trends and putting plans of action into place to assist in reducing or eliminating identified hazards.
- Sharing information regionally on injury trends and prevention strategies.
- Continuing to facilitate existing safety programs and training that have played a key role in injury reduction.

KTHR Patient First Progress

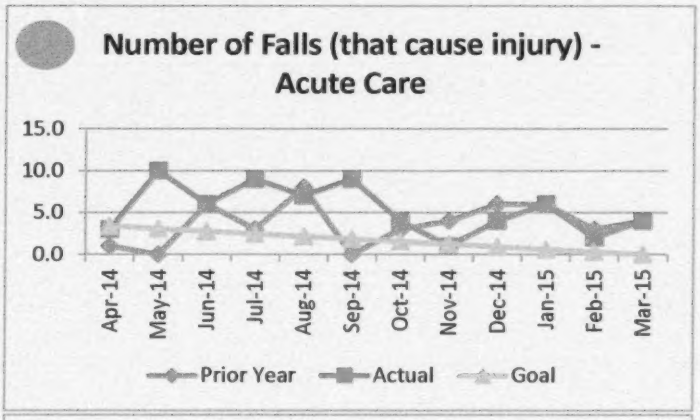
KTHR monitors a number of Quality, Cost, Delivery, Safety and Morale (QCDSM) metrics not considered strategic priorities in the 2014-15 fiscal year but are aligned to provincial outcome targets. These metrics also provide continued focus and support for quality improvement initiatives that benefit patients, clients, residents and their families.

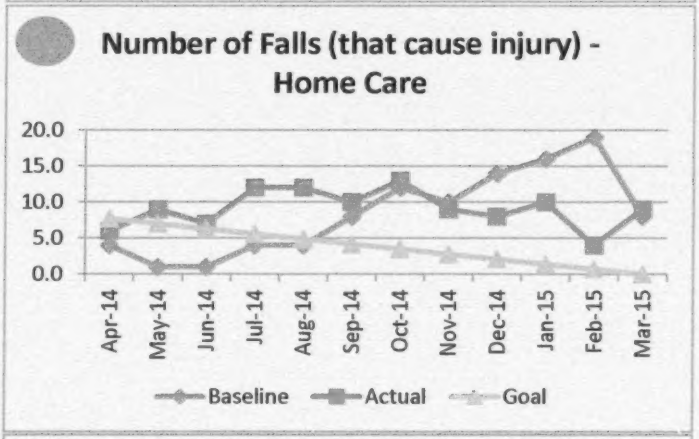
Falls

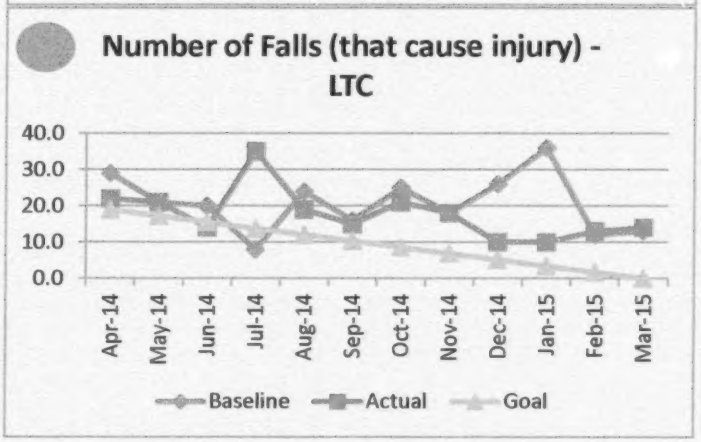
The KTHR falls reduction target is zero falls with injury in acute care, home care and long term care.

The regional fall program is focused on individualized approaches to care planning and addressing fall reduction. The cumulative efforts of providing customized solutions that fit the needs of each high risk individual have resulted in a reduction in falls though there is still significant work required to achieve the target.

Falls and injuries associated with falls take a physical and emotional toll on patients, clients and long term care residents. By focusing on prevention, the quality of life for patients and residents can be







Date Prepared: 04/13/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

improved and, as a result, the cost to the health care system can be reduced.

Fall reduction is an ongoing priority for the region. Falls reduction work has become part of daily management and is a prominent feature on visibility walls across the region.

A well-developed falls prevention strategy is in place in long term care and has been standardized in acute care. The impact of the regional least restraint policy, if any, on falls has not been determined as yet and will require further analysis to identify any correlations.

- Falls are a critical aspect of care conferencing in long term care.
- Falls prevention material is reviewed at daily huddles and information is updated on visibiltiy walls.
- "Falls Huddles" occur immediately after a fall to investigate and prevent further incidents.
- Fall risk assessments are completed on admission, monthly and after each fall.
- Purposeful rounding is being implemented among long term care sites.
- Creative staff scheduling is being used to address facilities with challenging environments and to ensure maximum staff are available on the floor while enabling staff to take breaks.
- Increased focus on balance exercises for residents and support for walking programs and strength training exercises is also a priority.

Acute care patients are often at higher risk of falls as the result of the severity of the condition or illness that resulted in their admission to acute care. There are also a growing number of ALC patients in acute care.

- Acute care patients at higher risk are identified during daily huddles and monitored to prevent falls.
- Acute care huddles are used to educate staff about the falls policy as well as identify and review patients at high risk of fall each day.
- On admission and throughout the day, staff identify extremely high risk patients through assessment of criteria including level of cognition, falls history, physical strength, comorbidities and use of mobility aides. This assessment is completed in addition to the Morse Fall Risk Assessment Tool.
- Patients identified as extremely high risk for falls are moved to rooms closest to the nurse's station, are included in hourly rounds, have their bed alarms set and assessed at change of shift by staff and have documentation white boards in their rooms indicating they are at high risk for falls.

Home care has historically tracked falls through incident reporting. Through the introduction of daily management and daily morning huddles, the process changed to include tracking and reporting falls which occurred "since yesterday" in order to facilitate real-time discussions about contributing factors and possible care planning interventions to prevent future falls. Tracking also includes falls reported by home care clients where there was evidence of injury. This step was taken to become more proactive, identify causative/relating factors, initiate early intervention before there more critical injury resulted, and align with provincial guidelines for reporting.

- Home care has reviewed the falls prevention program and adopted the falling star symbol used in the long term care program to identify those at high risk.
- The nursing assessment tool has been modified to incorporate the RAI-HC (Resident Assessment Instrument-Home Care), an internationally validated assessment tool adopted by the province for performing comprehensive client assessments, which helps determine which clients are at high risk.
- The regional falls prevention brochure is included with the in-home chart for the education of each client.

Medication Reconciliation

Most patients, clients and residents reciving health care services in KTHR have chronic diseases managed by multiple medications. Medication regimes are often complex and have the potential for adverse drug events/errors resulting in ill health, hospitalization and risk of further injuries such as falls. Research indicates medication reconciliation at transition points decreases harm to individuals, shortens length of hospital stay and reduces re-hospitalization.

In KTHR all acute care facilties implemented medication reconciliation on admission and discharge. Compliance with discharge is currently a greater challenge than admission. Many facilities struggle with lack of pharmacy services on weekends and no Targeted Date of Discharge (TDD), which has been identified for future improvement work.

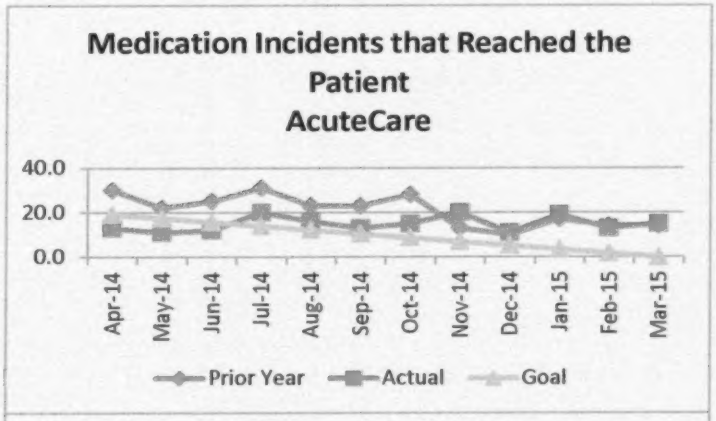
Although the region did not reach the target, there was an overall reduction in acute care and home care medication incidents that reached the patient/client as compared to the previous year. Long term care experienced a steady increase in the number of medication incidents that reached the resident over the course of the fiscal year.

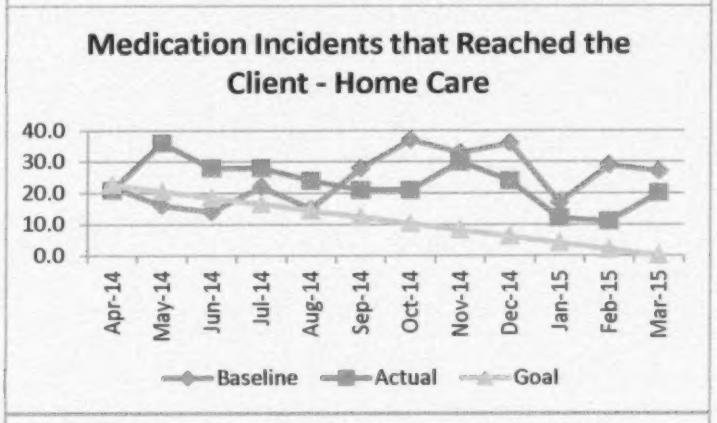
Various factors resulted in the increase in long term care medication incidents. Incident analysis determined causes of medication errors in long term care included:

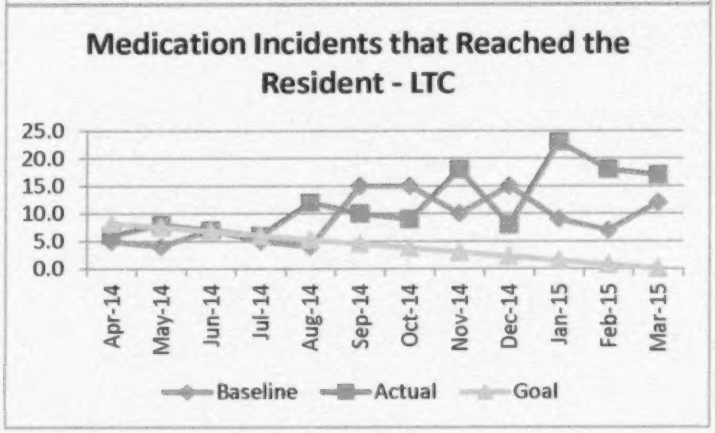
- Medication given to the wrong resident
- Incorrect medication or dose given
- Missed dose
- A fentanyl patch that was not removed
- Packaging/transcription errors from pharmacy

Further investigation into root cause identified additional factors, including:

- nurses are interrupted multiple times during medication passes
- human error
- nurses not utilizing the 7 R's of medication administration
- communication concerns between pharmacy and facility
- medications scheduled at "off" times
- new/changing staff







Date Prepared: 04/13/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

To address the rate of medication incidents in long term care, KTHR will focus on minimizing interruptions by ensuring office staff are available during major, daily medication pass time to answer phone calls; post signage to make visitors, residents and other staff aware not to interrupt the nurse during medication

passes; use staff meetings, visibility walls and daily management to educate staff not to interrupt the nurse during medication passes; and providing a message board on the medication cart for staff to write down concerns for nurses to be dealt with at the conclusion of the medication pass.

In addition, staff is being re-educated on the 7 R's of medication administration. Contract meetings with community pharmacies providing services to long term care also featured discussion surrounding concerns with pharmacy errors and plans to eliminate them.

Acute care is focusing improvement work on medication reconciliation on discharge. The provincial goal is 65% by January 2015 and 100% by April 2015. KTHR met the target in January but was below the target in February.

Incident analysis revealed:

- nurses and physicians have not received adequate education and follow-up;
- a regional lead for medication reconciliation education has not been identified;
- there is a lack of understanding about provincial and regional goals surrounding reducing the risk to patient safety through medication reconciliation at discharge;
- nurses are frequently missing the stopped/hold medications from medication reconciliation at admission; and
- physicians are missing the quantity column for medications.

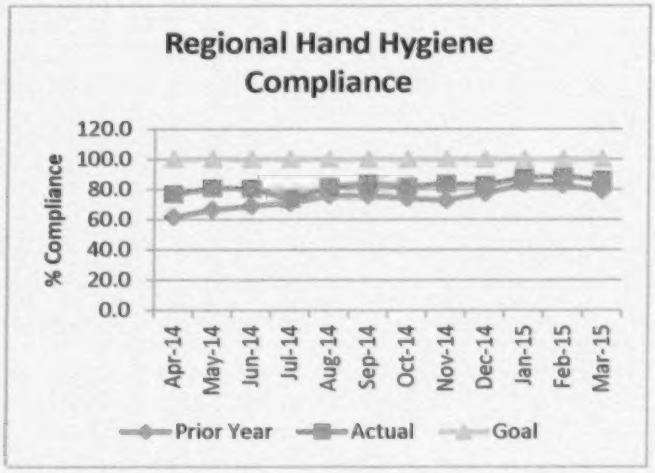
KTHR is reviewing medication reconciliation results with Facility Administrators in an effort to identify gaps. Education focused on understanding medication reconciliation at discharge is being implemented in all acute facilities in the region with an initial focus on the facilities that scored 50% or less on discharge audits. Audit results and defects are being reviewed at regional Medical Advisory Committee (MAC) meetings. Staff members requiring additional support will be identified by Facility Administrators and provided with one-on-one education.

Hand Hygiene Compliance

Monthly hand washing audits have been in place since January 2013. KTHR initially set the target at 70% compliance with a gradual increase to 100%. Regional compliance rates have improved over the previous year but remain below the target. Insufficient cleaning times, staff assuming hand hygiene is being completed correctly, missed opportunities for hand hygiene, and dress code issues with long-sleeves are impacting compliance rates.

To improve rates, KTHR is taking a multi-faceted approach including:

- monthly hand hygiene audits reporting rates less than 75% are required to submit corrective action plans;
- posting hand hygiene audit results on visibility walls and discussing rates at daily huddles;
- increased visibility of clocks in facilities to increase compliance with appropriate hand cleaning times; and,
- auditor's taking the opportunity to teach and provide education while conducting audits.



Date Prepared: 04/27/2015
Report Contact: Pamela McKay, VP Integrated Health Services
Refresh Cycle: Monthly

In the new fiscal year, KTHR will launch Germ Smart, a Saskatoon Health Region-brokered hand hygiene awareness campaign involving schools, community and health care.

Better Value Award

The Kelvington Integrated Health Care Facility 3P team was one of eight teams honoured with the presentation of a 2014 Pursuing Excellence Award at the 4th annual Saskatchewan Health Care Quality Summit. The Pursuing Excellence awards are presented to individual organizations and teams doing outstanding improvement work relating to the health systems four aims: Better Health, Better Care, Better Value and Better Teams. The Kelvington 3P team received a Better Value award. The goal of the Kelvington 3P was to design a facility in Kelvington that would best support patient-centred, interdisciplinary, collaborative car and integration across the continuum of care. The 3P team met on numerous occasions to redesign processes, improve flow and eliminate waste through a design process which resulted in substantial savings in the construction costs for the addition of the acute care facility and primary health care clinic that will be reinvested into the renovation and renewal of Kelvindell Lodge.

Melfort On-Call Clinic

Access and the quality of patient care improved for patients in Melfort and area as the result of

the addition of an on-call clinic at the Melfort Hospital in February. The implementation of the on-call clinic was the result of Value Stream Mapping (VSM) of the Emergency Room at Melfort Hospital in the fall of 2013 that identified several opportunities for improvement. The on-call clinic was established in an effort to help redirect non-urgent patients from visiting the emergency room and to improve access to non-urgent medical services for patients who do not have a family physician or whose family physician is away.

Increasing physical activity in licensed daycares

The Kelsey Trail Health Region-led *Eat Well, Play Well...Together We Are Better* (EWPW) working group's efforts to promote increased physical activity in licensed day cares gained international attention at the 2014 Global Summit on the Physical Activity of Children held in Toronto in May 2014. The work of the EWPW working group supports development of daycare policies in three areas: physical activity requirements based on Canadian Physical Activity and Sedentary Behaviour Guidelines for the Early Years; physical activity programming through the promotion of LEAP BC™ resources which focus on learning through play and support healthy child development through physical movement, healthy eating, language development and early literacy; and workplace wellness including stretching exercises staff can do with children.

Medical clinic services return to Rose Valley

Medical services returned to the Town of Rose Valley in January 2015. Rose Valley Medical Clinic re-opened one day a week with medical services provided by the Physicians and Nurse Practitioner from Kelvington who visit the community on a rotating basis. Medical services in Rose Valley were discontinued for several years due to a physician shortage in Kelvington. KTHR has been fortunate to secure a full complement of physicians in Kelvington as well as a Nurse Practitioner to enable the service to return to the community of Rose Valley.

Digital imaging strategy approved

In December 2014, the KTRHA approved the region's digital imaging strategy which will see upgrading of the Computed Radiography (CR) technology to Digital Radiography (DR) technology in all six acute care sites as well as the Carrot River Health Centre. CR units financed by community trusts and foundations in 2007 are nearing the end of their useful life. With the support of the community trusts and foundations in all six acute care sites and Carrot River, KTHR will align all digital imaging technology in the region through the upgrade. DR technology is considered industry standard.

Management Report

May 27, 2015

KELSEY TRAIL HEALTH REGION
REPORT OF MANAGEMENT

The accompanying financial statements are the responsibility of management and are approved by the Kelsey Trail Regional Health Authority. The financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards and the Financial Reporting Guide issued by Saskatchewan Health, and of necessity includes amounts based on estimates and judgements. The financial information presented in the annual report is consistent with the financial statements.

Management maintains appropriate systems of internal control, including policies and procedures, which provide reasonable assurance that the Region's assets are safeguarded and the financial records are relevant and reliable.

The Authority delegates the responsibility of reviewing the financial statements and overseeing Management's performance in financial reporting to the Finance, Audit & Risk Management Committee. The Finance, Audit & Risk Management Committee meets with the Authority, Management and the external auditors to discuss and review financial matters and recommends the financial statements to the Authority for approval. The Authority approves the annual report and, with the recommendation of the Finance, Audit & Risk Management Committee, approves the financial statements.

The appointed auditor conducts an independent audit of the financial statements and has full and open access to the Finance, Audit & Risk Management Committee. The auditor's report expresses an opinion on the fairness of the financial statements prepared by Management.

Shane Merriman, CPA, CMA
Chief Executive Officer

Connie Glaves
VP Corporate Services

2014-15 Financial Overview

Kelsey Trail Health Region recorded an operational surplus, before interfund transfers, of $1,653,108. The region is required to make transfers from the operating fund to the capital fund for mortgage payments, the principal portion of the loan on the region's Energy Performance loan, and necessary allocations to Maintenance & Replacement Reserves. Annualized transfers from operating to capital for the 2014-15 fiscal year amounted to $740,896 leaving an adjusted surplus after interfund transfers of $912,212. The KTRHA approved a capital allocation of 75%, or $684,159, to leave an operational surplus of $228,053.

The region achieved a balanced budget as the result of revenues due to pension funding in the amount of $311,000 and secondments to 3sHealth for the Enterprise Resource Management (ERP) business case in the amount of $155,000. Vacancies, administrative restructuring and supply cost savings in lab and information technology generated an additional $2,500,000 of which a portion was offset by sick and overtime costs.

The 2014-15 budget was based on budgeted revenues of $124,071,313, an increase of 2.03% over the previous year. Budgeted expenditures of $123,347,596 increased by 2.04% over the same period, not including appropriations from the operating to the capital fund of .64% required for mortgage payments, the Energy Performance Contract Loan and SHC Reserves. The majority of budgeted revenues are related to increases in compensation-related expenses for health care providers. Salaries, benefits and medical remuneration account for 83%, or $101.3 million, of KTHR's budget.

The 2014-15 budget addressed the Ministry's cumulative efficiency targets to date of $5.649 million, which included targeted savings through efficiencies in attendance support, shared services and general efficiencies required since the 2010-11 fiscal year. The region was expected to achieve an additional $1.543 million in general efficiency targets in 2014-15. Though not required to meet any efficiency targets for shared services or attendance support in 2014-15, work in this area continued in an attempt to address sick, overtime and WCB costs. This work will be extremely important to managing actual costs. Regional budgeting efficiency planning initiatives also include monthly reports to help monitor budget variances and communicate changes.

Several factors contributed to achieving the region's $1.543 million efficiency target including a WCB rate reduction, administrative efficiencies, vacancy management, supply or non-salary savings and minor service changes. An improved hiring process and vacancy management continue to play an important role in achieving efficiencies. Several quality improvement initiatives were undertaken in an effort to eliminate waste and create value for patients and

clients. The region's financial viability continues to take priority and the region continues to make every effort to ensure change is managed with a focus on minimizing impact on patients while achieving efficiencies and best practice.

The region's operating pressures are influenced by several factors, particularly the growing costs associated with supporting current health services including:

- advances in technologies, procedures and drugs;
- increased emphasis on environmental/infection control, quality improvement and patient safety;
- human resources shortages; and
- education and training of staff, both mandatory and other.

Regionally, services and processes continue to be reviewed in an effort to adopt best practice and achieve further efficiency, including the implementation of quality improvement initiatives. Strategies continue to be developed to achieve a balanced financial position in 2015-16 in an effort to achieve long term sustainability and fiscal efficiency.

Capital equipment requests continue to surpass the capital funding available to the region. Advances in technologies, aging equipment and facilities impact the ability to meet the capital needs of the region. The 2014-15 capital budget of $1.9 million targeted new technology and equipment to address quality and patient safety. Priority items on the capital budget included additional medical and surgical equipment, patient care and safety, lab and diagnostic imaging equipment, technology and the ongoing work associated with the planning and construction of capital projects in Kelvington and Tisdale. In 2014-15, the capital equipment funding allocation was $225,000 for general capital equipment. Items that were not considered priority for the 2014-15 capital budget were added to the region's five-year capital equipment plan.

In 2014-15, KTHR received $527,500 in one-time funding to address Life Safety/Emergency & Infrastructure projects.

KTHR received funding of $250,000 through the Long Term Care (LTC) Urgent Action Fund to provide recreation activities for long term care residents on weekends. This funding provided an eight hour shift on both Saturday and Sunday for a Recreation Worker at each long term care facility in KTHR to address priority issues identified through the CEO's tour of KTHR long term care facilities earlier in the year. KTHR will receive annualized funding of $250,000 from the Ministry of Health to support these initiatives.

The long term care replacement project in Tisdale proceeded on schedule in 2014-15 with the renovations to the former Newmarket Manor completed in February 2015. The renovations included the addition of one common kitchen, dining and living area as well as aesthetic

upgrades to the interior and exterior of the building. Sasko Park Lodge residents moved into the renovated portion of the building on March 17, 2015, exactly one year to the day after the former residents of Newmarket Manor moved into the newly constructed cottages. Sasko Park Lodge will now be decommissioned. The new facility, which includes the new construction and the renovation, will be known as Newmarket Place.

Funding commitments toward the 20% local municipal share of the Kelvington integrated facility project were confirmed in May of 2014 and the Ministry of Health approved awarding of the project tender to Humboldt Lumber Mart in September. An official sod turning was held in October 2014. Construction of the new acute care and primary health care areas has proceeded on schedule with renovations to Kelvindell Lodge, the existing long term care facility, scheduled to begin in January 2016. Fundraising for the equipment and furnishings for the new facility has been undertaken by the Kelvington & District Health Care Facility Foundation.

Community Health Services in Tisdale officially relocated from the RECplex to the Northeast Healthplex in August of 2014. The move saw the relocation of physiotherapy, occupational therapy, public health nursing and the Community Wellness Coordinator from the RECplex and the relocation of the Travel Health Clinic from Tisdale Hospital. Visiting services such as pediatric physical therapy, speech language pathology and dental therapy also have space in the new location. The relocation of these services to the Healthplex improves client access to physicians, mental health and addiction services, acute care, home care and long term care staff. It also enhances acute care patient and long term care resident access to Community Health Services. The relocation of Community Health Services to the Healthplex provided an opportunity to co-locate KTHR Payroll and Benefits, previously located at Regional Office, with Scheduling, previously located in Tisdale Hospital, in the RECplex space.

KTHR has been working to complete its highest priority life safety/emergency and infrastructure needs with $4.1 million in infrastructure funding received through the provincial government's $1.5 billion *Ready for Growth* infrastructure initiative initially announced in 2008-09. In 2014-15, the region received one-time funding in the amount of $527,500 to address projects including upgrading, replacement or installation of nurse call systems, and roof repairs. In addition to the safety equipment improvements, the region also completed work on emergency generators, boilers and building repairs and maintenance.

Community trusts, foundations and auxiliaries provide invaluable support to the region in providing financial resources to help meet capital equipment needs. KTHR will be relying on community trusts and foundations to confirm community-based capital funding commitments to support the regional diagnostic imaging strategy and cover the capital costs associated with upgrading the existing Computed Radiography (CR) rooms to Digital Radiography (DR) technology in 2015-16.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY

AUDITED FINANCIAL STATEMENTS

YEAR ENDED MARCH 31, 2015

NeuPath Group, PC Inc.
Chartered Accountants

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
Kelsey Trail Regional Health Authority

We have audited the accompanying financial statements of Kelsey Trail Regional Health Authority, which comprise the statement of financial position as at March 31, 2015, the statements of operations, changes in fund balances and cash flow for the year ended March 31, 2015, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform an audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design auditor procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Qualified Opinion

One of the Authority's capital assets under construction is held under a shared ownership arrangement with the Ministry of Health. Following the direction of the Ministry of Finance, the Authority recorded their proportionate ownership interest in tangible capital assets under construction rather than the full cost of the capital projects. The accounting for this capital project constitutes a departure from Canadian public sector accounting standards. Had the Authority accounted for the full cost of the capital project, capital fund revenue from the Ministry of Health for the year ended March 31, 2015 would have increased by $2,045,780. On a cumulative basis, an increase in capital assets of $2,659,301, a decrease in accounts receivable of $217,454, and a corresponding increase in restricted fund balances of $2,441,847 would be required in the statement of financial position to reflect these transactions in accordance with Canadian public sector accounting standards as at March 31, 2015.

INDEPENDENT AUDITORS' REPORT - ***Continued***

Qualified Opinion

In our opinion, except for the effects of the matter described in the Basis for Qualified Opinion paragraph, the financial statements present fairly, in all material respects, the financial position of Kelsey Trail Regional Health Authority as at March 31, 2015, its results of operations, its changes in fund balances and its cash flows for the year then ended in accordance with Canadian public sector accounting standards for government not-for-profit organizations.

Chartered Accountants

Nipawin, Saskatchewan
May 27, 2015

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF FINANCIAL POSITION
As at March 31, 2015

Statement 1

	Operating Fund	Restricted Funds: Capital Fund	Restricted Funds: Community Trust Fund	Total 2015	Total 2014
ASSETS					
Current assets					
Cash and short-term investments (Schedule 2)	$ 9,039,356	$ 3,251,485	$ 3,516,800	$ 15,807,641	$ 18,775,826
Accounts receivable					
Ministry of Health - General Revenue Fund	69,872	217,454	-	287,326	655,443
Other	1,149,039	459,756	-	1,608,795	1,327,314
Inventory	543,985	-	-	543,985	584,485
Prepaid expenses	788,916	-	-	788,916	870,667
	11,591,168	3,928,695	3,516,800	19,036,663	22,213,735
Investments (Schedule 2)	1,280,293	-	-	1,280,293	1,222,537
Other assets	33,070	-	-	33,070	32,113
Capital assets (Note 3)	-	57,556,295	-	57,556,295	57,670,888
Total Assets	$ 12,904,531	$ 61,484,990	$ 3,516,800	$ 77,906,321	$ 81,139,272
LIABILITIES & FUND BALANCES					
Current liabilities					
Accounts payable	$ 3,690,841	$ 170,081	$ -	$ 3,860,922	$ 4,309,720
Accrued salaries	2,761,970	-	-	2,761,970	4,487,306
Vacation payable	7,123,054	-	-	7,123,054	7,205,492
Long term debt - current (Note 5)	-	709,656	-	709,656	673,801
Deferred revenue (Note 6)	654,635	-	-	654,635	1,087,541
	14,230,500	879,737	-	15,110,237	17,763,860
Long term liabilities					
Long term debt (Note 5)	-	8,017,685	-	8,017,685	8,752,239
Employee Future Benefits (Note 10)	4,092,500	-	-	4,092,500	4,113,400
Total Liabilities	18,323,000	8,897,422	-	27,220,422	30,629,500
Fund Balances:					
Invested in capital assets	-	48,828,954	-	48,828,954	48,244,847
Externally restricted (Schedule 3)	-	1,822,602	3,516,800	5,339,402	5,890,298
Internally restricted (Schedule 4)	-	1,936,012	-	1,936,012	2,021,149
Unrestricted	(5,418,469)	-	-	(5,418,469)	(5,646,522)
Fund balances – (Statement 2)	(5,418,469)	52,587,568	3,516,800	50,685,899	50,509,772
Total Liabilities & Fund Balances	$ 12,904,531	$ 61,484,990	$ 3,516,800	$ 77,906,321	$ 81,139,272

Commitments (Note 4)
Pension Plan (Note 10)
Contingent Liabilities (Note 18)

Approved on behalf of the Board of Directors:

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF OPERATIONS AND CHANGES IN FUND BALANCES
For the Year Ended March 31, 2015

Statement 2

	Operating Fund			Restricted			
	Budget 2015 (Note 11)	2015	2014	Capital Fund 2015	Community Trust Fund 2015	Total 2015	Total 2014
REVENUES							
Ministry of Health - General Revenue Fund	$ 112,037,913	$ 113,180,284	$ 111,685,145	$ 2,159,384	$ -	$ 2,159,384	$ 5,317,952
Other Provincial	1,351,673	1,131,658	1,478,611	320,942	-	320,942	336,544
Federal Government	-	1,440	2,582	-	-	-	-
Patient & Client Fees	8,525,647	8,525,861	8,368,366	-	-	-	-
Out of Province (reciprocal)	480,921	543,837	500,959	-	-	-	-
Out of Country	22,733	29,799	23,680	-	-	-	-
Donations	30,000	19,812	22,234	924,699	174,760	1,099,459	1,390,417
Ancillary	758,376	771,664	750,541	-	-	-	-
Investment	150,000	198,268	151,849	37,299	49,482	86,781	111,833
Recoveries	592,100	770,388	561,729	-	-	-	-
Research Grants	-	-	-	-	-	-	-
Other	121,950	182,042	129,022	5,200	-	5,200	-
Total revenues	**124,071,313**	**125,355,053**	**123,674,718**	**3,447,524**	**224,242**	**3,671,766**	**7,156,746**
EXPENSES							
Inpatient & resident services							
Nursing Administration	3,559,813	3,658,382	4,813,385	-	-	-	-
Acute	14,703,858	15,111,440	14,852,645	1,664,763	9,260	1,674,023	1,704,322
Supportive	18,745,108	19,312,977	18,395,377	2,020,095	8,925	2,029,020	1,270,298
Integrated	5,740,016	5,790,194	5,622,635	1,172,930	2,735	1,175,665	1,181,808
Rehabilitation	-	-	-	-	-	-	-
Mental Health & Addictions	-	-	-	-	-	-	-
Total Inpatient & Resident Services	**42,748,795**	**43,872,993**	**43,684,042**	**4,857,788**	**20,920**	**4,878,708**	**4,156,428**
Physician Compensation	**11,005,099**	**11,021,935**	**10,681,297**	-	-	-	-
Ambulatory Care Services	**3,187,496**	**3,238,881**	**3,132,949**	-	-	-	-
Diagnostic & Therapeutic Services	**11,938,624**	**11,463,441**	**11,219,605**	-	-	-	-
Community Health Services							
Primary Health Care	2,525,790	2,467,068	2,589,441	-	25	25	1,000
Home Care	7,984,108	8,017,701	7,809,068	-	-	-	-
Mental Health & Addictions	2,832,971	2,718,201	2,630,305	-	-	-	-
Population Health	5,394,464	4,985,354	5,051,423	-	-	-	-
Emergency Response Services	3,811,442	3,873,540	3,840,595	131,852	-	131,852	124,570
Other Community Services	610,015	630,024	594,758	45,267	-	45,267	36,325
Total Community Health Services	**23,158,790**	**22,691,888**	**22,515,590**	**177,119**	**25**	**177,144**	**161,895**
Support Services							
Program Support	7,529,358	7,104,458	7,748,031	-	-	-	-
Operational Support	23,341,136	23,881,623	23,502,629	92,894	-	92,894	92,649
Employee Future Benefits	-	(20,900)	(35,700)	-	-	-	-
Other Support	438,298	447,626	439,999	-	-	-	-
Environmental Remediation (Note 17)	-	-	-	-	-	-	-
Total Support Services	**31,308,792**	**31,412,807**	**31,654,959**	**92,894**	**-**	**92,894**	**92,649**
Ancillary	-	-	-	-	-	-	-
Total Expenses (Schedule 1)	**123,347,596**	**123,701,945**	**122,888,442**	**5,127,801**	**20,945**	**5,148,746**	**4,410,973**
Excess (Deficiency) of Revenues over Expenses	**$ 723,717**	**1,653,108**	**786,276**	**(1,680,277)**	**203,297**	**(1,476,980)**	**2,745,773**
Interfund Transfers							
Building renovations (EPC Loan Payments)		(200,586)	(190,197)	200,586	-	200,586	190,197
Capital asset purchases		-	-	206,065	(206,065)	-	-
SHC reserves		(153,828)	(170,357)	153,828	-	153,828	170,357
Capital Equipment		(684,159)	-	684,159	-	684,159	-
Mortgage payments		(386,482)	(394,223)	386,482	-	386,482	394,223
Total Interfund Transfers		(1,425,055)	(754,777)	1,631,120	(206,065)	1,425,055	754,777
Increase (Decrease) in Fund Balances		**228,053**	**31,499**	**(49,157)**	**(2,768)**	**(51,925)**	**3,500,551**
Fund balances, beginning of year		(5,646,522)	(5,678,021)	52,636,725	3,519,568	56,156,293	52,655,743
Fund balances, end of year		$ (5,418,469)	$ (5,646,522)	$ 52,587,568	$ 3,516,800	$ 56,104,368	$ 56,156,294

The accompanying notes and schedules are part of these financial statements.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
STATEMENT OF CASH FLOW
For the Year Ended March 31, 2015

Statement 3

	Operating Fund		Restricted Fund			
	2015	2014	Capital Fund	Community Trust Fund	Total 2015	Total 2014
Cash Provided by (used in):						
Operating activities:						
Excess (deficiency) of revenue over expenditure	$ 1,653,108	$ 786,276	$ (1,680,277)	$ 203,297	$ (1,476,980)	$ 2,745,773
Net change in non-cash working capital (Note 7)	(1,088,284)	1,556,811	(1,413,207)	-	(1,413,207)	3,278,493
Amortization of capital assets	-	-	4,910,301	-	4,910,301	4,053,377
Investment income on long-term investments	-	-	-	-	-	-
(Gain)/loss on disposal of capital assets	-	-	-	-	-	-
	564,824	2,343,087	1,816,817	203,297	2,020,114	10,077,644
Capital activities:						
Purchase of capital assets						
Buildings/construction	-	-	(3,409,463)	-	(3,409,463)	(8,338,546)
Equipment	-	-	(1,386,245)	-	(1,386,245)	(1,984,173)
Proceeds on disposal of capital assets						
Buildings	-	-	-	-	-	-
Equipment	-	-	-	-	-	-
	-	-	(4,795,708)	-	(4,795,708)	(10,322,719)
Investing activities						
Sale (Purchase) of long-term investments	(58,713)	(2,236)	-	-	-	-
	(58,713)	(2,236)	-	-	-	-
Financing activities						
Repayment of debt	-	-	(698,701)	-	(698,701)	(663,412)
	-	-	(698,701)	-	(698,701)	(663,412)
Net increase (decrease) in cash & short-term investments during the year	506,111	2,340,851	(3,677,592)	203,297	(3,474,295)	(908,488)
Cash & short-term investments, beginning of year	9,958,300	8,372,227	5,297,957	3,519,568	8,817,525	8,971,236
Interfund transfers (Statement 2)	(1,425,055)	(754,777)	1,631,120	(206,065)	1,425,055	754,777
Cash & short-term investments, end of year	$ 9,039,356	$ 9,958,300	$ 3,251,485	$ 3,516,800	$ 6,768,285	$ 8,817,526

The accompanying notes and schedules are part of these financial statements.

1. Legislative Authority

The Kelsey Trail Regional Health Authority (RHA) operates under *The Regional Health Services Act* (The Act) and is responsible for the planning, organization, delivery, and evaluation of health services it is to provide within the geographic area known as the Kelsey Trail Health Region, under section 27 of The Act. The Kelsey Trail RHA is a non-profit organization and is not subject to income and property taxes from federal, provincial, and municipal levels of government. The RHA is a registered charity under the *Income Tax Act* of Canada.

2. Significant Accounting Policies

These financial statements have been prepared in accordance with Canadian Public Sector Accounting (PSA) standards, issued by the Public Sector Accounting Board and published by CPA Canada. The RHA has adopted the standards for government not-for-profit organizations, set forth at PSA Handbook section PS 4200 to PS 4270. The RHA has also adopted section PS 3260, Liability for Contaminated Sites, as further explained in Note 17.

During the 2012-13 fiscal year, the Authority entered into a shared ownership arrangement with the Ministry of Health for the Kelvington Integrated Health Facility capital project. Following the direction of the Ministry of Health, as set out by the Ministry of Finance, the Authority recorded their proportionate ownership interest in tangible capital assets under construction rather than the full cost of the capital project. The accounting for this capital project constitutes a departure from Canadian public sector accounting standards.

a) Health Care Organizations

i) The RHA has agreements with and grants funding to the following prescribed HCOs and third parties to provide health services:

Nipawin Oasis Community Centre Co-operative Ltd.
Kelvington Ambulance Care Ltd.
Tisdale Ambulance Care Ltd.
Shamrock Ambulance Care Ltd.
North East EMS
Melfort Ambulance Service
Town of Naicam

Note 9 b) i) provides disclosure of payments to prescribed HCOs and third parties.

ii) Fund Raising Foundations

The Nipawin Region Health Foundation Inc. and the North Central Health Care Foundation Inc. are incorporated under *The Non-Profit Corporations Act* and are registered charities under *The Income Tax Act of Canada.*

2. Significant Accounting Policies – continued

Under the Foundations' Articles of Incorporation, all funds raised by the Foundations after payments of reasonable expenses must be paid to the RHA (or must be used to purchase and transfer assets to the RHA, for the purpose to provide health care services.)

These financial statements do not include the financial activities of the two Foundations. Alternatively, Note 9 b) ii) provides supplementary information on the Foundations.

b) Fund Accounting

The accounts of the RHA are maintained in accordance with the restricted fund method of accounting for revenues. For financial reporting purposes, accounts with similar characteristics have been combined into the following major funds:

i) Operating Fund

The operating fund reflects the primary operations of the RHA including revenues received or receivable for provision of health services from the Ministry of Health - General Revenue Fund, and billings to patients, clients, the federal government and other agencies for patient and client services. Other revenue consists of donations, recoveries and ancillary revenue. Expenses are for the delivery of health services.

ii) Capital Fund

The capital fund is a restricted fund that reflects the equity of the RHA in capital assets after taking into consideration any associated long-term debt. The capital fund includes revenues received or receivable from the Ministry of Health – General Revenue Fund provided for construction of capital projects and/or the acquisition of capital assets. The capital fund also includes donations designated for capital purposes by the contributor. Expenses consist primarily of amortization of capital assets.

iii) Community Trust Fund

The community trust fund is a restricted fund that reflects community generated assets transferred to the RHA in accordance with the pre-amalgamation agreements signed with the amalgamating health corporations. The assets include cash and investments initially accumulated by the health corporations in the RHA from donations or municipal tax levies. These assets are accounted for separately and use of the assets is subject to restrictions set out in pre-amalgamation agreements between the RHA and the health corporations.

2. Significant Accounting Policies – continued

c) Revenue

Unrestricted revenues are recognized as revenue in the Operating Fund in the year received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

Restricted revenues related to general operations are recorded as deferred revenue and recognized as revenue of the Operating Fund in the year in which the related expenses are incurred. All other restricted revenues are recognized as revenue of the appropriate restricted fund in the year.

d) Capital Assets

Capital assets are recorded at cost. Normal maintenance and repairs are expensed as incurred. Capital assets, with a life exceeding one year, are amortized on a straight-line basis over their estimated useful lives as follows:

Land improvements	1 - 20%
Buildings	2.5 - 10%
Equipment	3 – 33.33%

Donated capital assets are recorded at their fair value at the date of contribution (if fair value can be reasonably determined).

e) Inventory

Inventory consists of general stores, pharmacy, laboratory, linen and other. All inventories are held at the lower of cost or net realizable value as determined on a weighted average cost basis.

f) Employee Future Benefits

i) Pension

Employees of the RHA participate in several multi-employer defined benefit pension plans or a defined contribution plan. The RHA follows defined contribution plan accounting for its participation in the plans. Accordingly, the RHA expenses all contributions it is required to make in the year.

ii) Accumulated Sick Leave Benefit Liability

The RHA provides sick leave benefits for employees that accumulate but do not vest. The RHA recognizes a liability and an expense for sick leave in the period which employees render services in return for the benefits. The liability and expense is developed using an actuarial cost method.

2. Significant Accounting Policies – continued

g) Measurement Uncertainty

These financial statements have been prepared by management in accordance with Canadian Public Sector Accounting standards. In the preparation of the financial statements, management makes various estimates and assumptions in determining the reported amounts of assets and liabilities, revenues and expenses and in the disclosure of commitments and contingencies. Changes in estimates and assumptions will occur based on the passage of time and the occurrence of certain future events. The changes will be reported in earnings in the period in which they become known.

h) Financial Instruments

The RHA has classified its financial instruments into one of the following categories: i) fair value or ii) cost or amortized cost.

All financial instruments are measured at fair value upon initial recognition. The fair value of a financial instrument is the amount at which the financial instrument could be exchanged in an arm's length transaction between knowledgeable and willing parties under no compulsion to act. The following financial instruments are subsequently measured at cost or amortized cost:

- Accounts receivable
- Short term and long term investments
- Accounts payable, accrued salaries and vacation payable
- Long term debt

As at March 31, 2015 the RHA does not have any material outstanding contracts or financial instruments with embedded derivatives.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported in the statement of operations.

i) Replacement Reserves

The RHA is required to maintain certain replacement reserves as a condition of receiving subsidy assistance from Saskatchewan Housing Corporation. Schedule 4 shows the changes in these reserve balances during the year.

j) Volunteer Services

The operations of the RHA utilize services of many volunteers. Because of the difficulty in determining the fair market value of these donated services, the value of these donated services is not recognized in the financial statements.

3. Capital Assets

	2015			2014
	Cost	Accumulated Amortization	Net Book Value	Net Book Value
Land	$ 639,590	$ -	$ 639,590	$ 639,590
Land Improvements	687,297	653,362	33,935	37,509
Buildings	119,165,279	70,564,943	48,600,336	49,013,770
Equipment	28,352,768	20,912,989	7,439,779	7,729,386
Construction in progress	842,655	-	842,655	250,633
	$ 149,687,589	$ 92,131,294	$ 57,556,295	$ 57,670,888

4. Commitments

a) Capital Asset Obligations

As at March 31, 2015 contractual obligations for acquisition of capital assets were $10,598,151 (2014 - $1,500,604). A co-ownership agreement exists with the Ministry of Health who will assume 77.5% of both the asset and the contractual obligation $8,213,567 (2014 $1,162,968).

b) Operating Leases

Minimum annual payments under operating leases on property and equipment over the next five years are as follows:

2016	$154,815
2017	83,690
2018	30,982
2019	9,540
2020	2,183

c) Contracted Health Care Organizations

The RHA continues to contract on an ongoing basis with private health service operators to provide health services in the RHA similar to those provided in the year ending March 31, 2014. Note 9 b) provides supplementary information on Health Care Organizations.

5. Long Term Debt

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2015	2014
Rose Valley Health Centre				
C.M.H.C., due October 1, 2021	1.12%	$38,797 Principal & interest Of which $10,141 is subsidized by SHC. Yielding an effective interest rate of 0.86%. Mortgage renewal date – February 1, 2020.	$ 246,117	$ 277,861
Newmarket Manor				
C.M.H.C., due March 1, 2023	1.12%	$140,124 Principal & interest Of which $38,186 is subsidized by SHC. Yielding an effective interest rate of 0.85%. Mortgage renewal date – February 1, 2020.	1,071,804	1,182,037
Kelvindell Lodge				
C.M.H.C., due October 1, 2020	2.11%	$33,508 Principal & interest Of which $364 is subsidized by SHC. Yielding an effective interest rate of 2.09%. Mortgage renewal date – January 1, 2019.	176,373	205,838
Red Deer Nursing Home				
C.M.H.C., due February 1, 2027	4.42%	$57,305 Principal & interest Of which $48,000 is subsidized by SHC. Yielding an effective interest rate of 0.91%. Mortgage renewal date – March 1, 2017.	531,374	564,605

5. Long Term Debt – continued

Title of Issue	Interest Rate	Annual Repayment Terms	Balance Outstanding 2015	2014
Arborfield Special Care Lodge				
C.M.H.C., due September 1, 2021	1.12%	$101,510 Principal & interest Of which $30,424 is subsidized by SHC. Yielding an effective interest rate of 0.82%. Mortgage renewal date – February 1, 2020.	$ 636,088	$ 719,344
Pineview Lodge				
C.M.H.C., due January 1, 2017	4.17%	$66,772 Principal & interest Of which $13,827 is subsidized by SHC. Yielding an effective interest rate of 3.31%. Mortgage renewal date – October 1, 2015.	117,686	178,220
C.M.H.C., due April 1, 2025	4.17%	$143,174 Principal & interest Of which $108,000 is subsidized by SHC. Yielding an effective interest rate of 1.22%. Mortgage renewal date – October 1, 2015.	1,178,783	1,271,125
Chateau Providence				
C.M.H.C., due October 1, 2026	4.31%	$96,109 Principal & interest Of which $72,000 is subsidized by SHC. Yielding an effective interest rate of 0.87%. Mortgage renewal date – December 1, 2016.	876,790	934,098
Energy Performance Contract				
Toronto Dominion Bank due October 15, 2026	5.33%	$413,885 Principal and interest	3,892,326	4,092,912
			8,727,341	9,426,040
Less: Current portion			709,656	673,801
			$ 8,017,685	$ 8,752,239

5. Long Term Debt – continued

Saskatchewan Housing Corporation (SHC) may provide a mortgage subsidy for supportive care homes financed by Canada Mortgage and Housing Corporation (CMHC). The subsidy may change when the mortgage renewal occurs.

For each of the mortgages, the RHA has pledged the related buildings of the special care homes as security. The term loan with the Toronto Dominion Bank is unsecured. Principal repayments required in each of the next five years are estimated as follows:

2016	$709,656
2017	779,603
2018	806,776
2019	835,155
2020	864,816
2021 and subsequent	4,731,334

6. Deferred Revenue

As at March 31, 2015	Balance Beginning Of Year	Less Amount Recognized	Add Amount Received	Balance End Of Year
Sask Health Initiatives				
Enhanced Dental Services	$ -	$ 67,217	$ 83,700	$ 16,483
LTC - Urgent Issues Action Fund	62,257	28,385	-	33,872
Nursing Recruitment Funding	82,236	30,480	-	51,756
Physician Recruitment Pilot	16,667	16,667	-	-
Primary Care - Physician Alternate Payment	500,136	8,460,136	7,960,000	-
Primary Care - Melfort PHC Team	125,000	57,046	-	67,954
Compensation	-	-	258,867	258,867
Physician Rural Locum	-	331,380	375,000	43,620
Total Sask Health	**786,296**	**8,991,311**	**8,677,567**	**472,552**
Non Sask Health Initiatives				
Kids First Targeted	301,246	548,407	429,244	182,083
Total Non Sask Health	**301,246**	**548,407**	**429,244**	**182,083**
Total Deferred Revenue	**$ 1,087,542**	**$ 9,539,718**	**$ 9,106,811**	**$ 654,635**

7. Deferred Revenue – continued

As at March 31, 2014	Balance Beginning Of Year	Less Amount Recognized	Add Amount Received	Balance End Of Year
Sask Health Initiatives				
Enhanced Dental Services	$ 19,098	$ 50,498	$ 31,400	$ -
Infection Prevention and Control	67,233	67,233	-	-
LTC - Urgent Issues Action Fund	-	59,907	122,164	62,257
Nursing Recruitment Funding	82,236	-	-	82,236
Physician Recruitment Pilot	50,000	33,334	-	16,666
Primary Care - Physician Alternate Payment	960,708	8,420,572	7,960,000	500,136
Primary Care - Melfort PHC Team	-	-	125,000	125,000
Pharmacist Services	118,608	118,608	-	-
Surgical Initiative	436,465	436,465	-	-
Total Sask Health	**1,734,347**	**9,186,617**	**8,238,564**	**786,295**
Non Sask Health Initiatives				
Kids First Targeted	318,270	586,646	569,622	301,246
Total Non Sask Health	**318,270**	**586,646**	**569,622**	**301,246**
Total Deferred Revenue	**$ 2,052,617**	**$ 9,773,263**	**$ 8,808,186**	**$ 1,087,541**

7. Net Change in Non-cash Working Capital

	Operating Fund		Restricted Funds			
	2015	2014	Capital Fund	Community Trust Fund	Total 2015	Total 2014
(Increase) Decrease in accounts receivable	$ 116,206	$ (66,476)	$ (29,568)	$ -	$ (29,568)	$ 2,221,697
(Increase) Decrease in inventory	40,500	(10,291)	-	-	-	-
(Increase) Decrease in prepaid expenses	81,752	55,536	-	-	-	-
Increase (Decrease) in accounts payable	934,839	(387,808)	(1,383,640)	-	(1,383,640)	1,056,796
Increase (Decrease) in accrued salaries	(1,725,337)	2,719,141	-	-	-	-
Increase (Decrease) in vacation payable	(82,438)	247,485	-	-	-	-
Increase (Decrease) in deferred revenue	(432,906)	(965,076)	-	-	-	-
Increase (Decrease) in employee future benefits	(20,900)	(35,700)	-	-	-	-
	$ (1,088,284)	$ 1,556,811	$(1,413,207)	$ -	$ (1,413,207)	$ 3,278,493

8. Patient and Resident Trust Accounts

The RHA administers funds held in trust for patients and residents using the RHA's facilities. The funds are held in separate accounts for the patients or residents at each facility. The total cash held in trust as at March 31, 2015 was $54,446 (2014 - $49,954). These amounts are not reflected in the financial statements.

9. Related Parties

These financial statements include transactions with related parties. The RHA is related to all Saskatchewan Crown Agencies such as ministries, corporations, boards, and commissions under the common control of the Government of Saskatchewan. The RHA is also related to non-Crown enterprises that the Government jointly controls or significantly influences. In addition, the RHA is related to other non-Government organizations by virtue of its economic interest in these organizations.

a) Related Party Transactions

Transactions with these related parties are in the normal course of operations. Amounts due to or from and the recorded amounts of transactions resulting from these transactions are included in the financial statements and the table below. They are recorded at exchange amounts which approximate prevailing market rates charged by those organizations and are settled on normal trade terms.

In addition, the RHA pays Provincial Sales Tax to the Saskatchewan Ministry of Finance on all its taxable purchases. Taxes paid are recorded as part of the cost of those purchases.

	2015	2014
Revenues		
Athabasca Regional Health Authority	$ 256,705	$ 88,066
Ministry of Education	505,377	645,007
Ministry of Health	115,339,668	117,003,097
Ministry of Justice	100,000	100,000
Sask Housing Corporation	320,942	336,544
SGI	132,430	95,495
	$ 116,655,122	$ 118,268,209

9. Related Parties - continued

Expenditures	2015	2014
Correctional Facilities Industries Revolving Fund	$ 627	$ 506
Cumberland Regional College	1,348	8,179
Health Quality Council	5,883	4,604
Mamawetan Churchill River Regional Health Authority	8,220	8,520
Ministry of Central Services	622,573	651,630
North East School Division	38,168	40,454
North Sask Laundry & Support Services	807,268	802,970
Prince Albert Parkland Regional Health Authority	39,165	72,395
Regina Qu'appelle Regional Health Authority	235	3,326
3sHealth	3,892,817	3,961,726
Sask Energy	976,206	1,174,213
Sask Housing	9,119	16,939
Sask Power	1,290,655	1,207,813
Sask Tel	586,939	750,760
Sask Workers Compensation Board	1,318,064	1,013,304
Saskatchewan Institute of Applied Science and Technology	845	3,859
Saskatchewan Transport Company	13,703	16,941
Saskatoon Regional Health Authority	375,806	341,271
SGI	26,084	9,951
SHEPP	10,731,010	11,417,441
Sunrise Regional Health Authority	-	52
Community Initiatives Fund	-	1,250
Cyress Regional Health Authority	-	200
eHealth Saskatchewan	140,829	175,102
Five Hills Regional Health Authority	-	1,050
Holy Trinity School Division	-	125
Physician Recruitment Agency of Saskatchewan	-	100
Saskatchewan Research Council	377	377
Information Services Corporation	-	20
Public Employees Benefits Agency	-	26,412
Queens Printer	-	5,723
Sask Liquor and Gaming Authority	-	1,381
	$ 20,885,941	$ 21,718,594

9. Related Parties - continued

	2015	2014
Accounts Receivable		
Ministry of Health	$ 287,326	$ 655,443
	$ 287,326	$ 655,443
Prepaid Expenditures		
Workers Compensation	$ 308,297	$ 317,735
	$ 308,297	$ 317,735
Accounts Payable		
Ministry of Health	$ -	$ -
	$ -	$ -

b) Health Care Organizations

i) Prescribed Health Care Organizations and Third Parties

The RHA has also entered into agreements with prescribed HCOs and Third Parties to provide health services.

These organizations receive operating funding from the RHA on a monthly basis in accordance with budget amounts approved annually. During the year, the RHA provided the following amounts to prescribed HCOs and Third Parties:

	2015	2014
Nipawin Oasis Community Centre Co-operative Ltd.	$ 47,776	$ 53,959
Kelvington Ambulance Care Ltd.	436,879	421,917
Tisdale Ambulance Care Ltd.	509,811	492,292
Shamrock Ambulance Care Ltd.	241,705	233,892
North East EMS	1,054,415	1,020,165
Melfort Ambulance Service	521,166	502,691
Town of Naicam	143,554	137,457
	$ 2,955,306	$ 2,862,373

ii) Fundraising Foundations

Fundraising efforts are undertaken through non-profit business corporations known as the Nipawin Region Health Foundation Inc. and North Central Health Care Foundation Inc. The Kelsey Trail Regional Health Authority has an economic interest in the Foundations. In accordance with donor-imposed restrictions, $455,775 (2014 - $476,122) of the foundations' net assets must be used to purchase specialized equipment or services. The Nipawin Region Health Foundation Inc. total expenses include contributions of $52,100 (2014 - $66,017) to the RHA. The North Central Health Care Foundation Inc. total expenses include contributions of $0 (2014 - $43,750) to the RHA.

10. Employee Future Benefits

a) Pension Plan

Employees of the RHA participate in one of the following pension plans:

1. Saskatchewan Healthcare Employees' Pension Plan (SHEPP) - This is jointly governed by a board of eight trustees. Four of the trustees are appointed by the Health Shared Services Saskatchewan (3sHealth) (a related party) and four of the trustees are appointed by Saskatchewan's health care unions (CUPE, SUN, SEIU, SGEU, RWDSU, and HSAS). SHEPP is a multi-employer defined benefit plan, which came into effect December 31, 2002. (Prior to December 31, 2002, this plan was formerly the SAHO Retirement Plan and governed by the 3sHealth Board of Directors).

2. Public Service Superannuation Plan (PSSP) (a related party) - This is also a defined benefit plan and is the responsibility of the Province of Saskatchewan.

3. Public Employees' Pension Plan (PEPP) (a related party) - This is a defined contribution plan and is the responsibility of the Province of Saskatchewan.

The RHA's financial obligation to these plans is limited to making required payments to these plans according to their applicable agreements. Pension expense is included in Compensation – Benefits in Schedule 1 and is equal to the RHA contributions amount below.

	2015			2014
	SHEPP[1]	PEPP	Total	Total
Number of active members	1,332	6	1,338	1,358
Member contribution rate, percentage of salary	8.10%-10.70%	6.00%-7.00%*		
RHA contribution rate, percentage of salary	9.07%-11.98%	6.00%-7.00%*		
Member contributions (thousands of dollars)	5,453	30	5,483	5,053
RHA contributions (thousands of dollars)	6,108	31	6,139	5,655

*Contribution rate varies based on employee group

1. Active members are employees of the RHA, including those on leave of absense as of March 31, 2015.

Inactive members are not reported by the RHA, their plans are transferred to SHEPP and managed directly by them.

Pension plan contribution rates have increased as a result of recent deficiencies in SHEPP. Any actuarially determined deficiency is the responsibility of participating employers and employees in the ratio of 1.12 to 1. Contribution rates will continue to increase until the next actuarial reports are completed.

10. Employee Future Benefits - continued

b) Accumulated Sick Leave Benefit Liability

The cost of the accrued benefit obligations related to sick leave entitlement earned by employees is actuarially determined using projected benefit method prorated on service and management's best estimate of inflation, discount rate, employee demographics and sick leave usage of active employees. The RHA has completed an actuarial valuation as of March 31, 2013, with an estimated valuation to March 31, 2015. Key assumptions used as inputs into the actuarial calculation are as follows:

	2015	2014
Discount rate	1.90%	2.85%
Earnings Increase	0%-2%	0%-2%

		2015		2014
Accrued benefit obligation, beginning of year	$	4,113,400	$	4,149,100
Cost for the Year		598,900		601,100
Benefits paid during the year		(619,800)		(636,800)
Accrued benefit obligation, end of year	$	4,092,500	$	4,113,400

11. Budget

The RHA Board approved the 2014-2015 budget plan on May 28, 2014.

12. Financial Instruments

a) Significant Terms and Conditions

There are no significant terms and conditions related to financial instruments classified as current assets or current liabilities that may affect the amount, timing, and certainty of future cash flows. Significant terms and conditions for the other financial instruments are disclosed separately in these financial statements.

b) Financial Risk Management

The RHA has exposure to the following risk from its use of financial instruments: credit risk, market risk and liquidity risk.

The Board ensures that the RHA has identified its major risks and ensures that management monitors and controls them. The Chairperson oversees the RHA's systems and practices of internal control, and ensures that these controls contribute to the assessment and mitigation of risk.

12. Financial Instruments - continued

c) Credit Risk

The RHA is exposed to credit risk from the potential non-payment of accounts receivable. The RHA is also exposed to credit risk from cash, short-term investments and investments.

The carrying amount of financial assets represents the maximum credit exposure as follows:

		2015		2014
Cash and short-term investments	$	15,807,641	$	18,775,826
Accounts receivable				
Ministry of Health - General Revenue Fund		287,326		655,443
Other		1,608,795		1,327,314
Investments		1,280,293		1,222,537
	$	18,984,055	$	21,981,120

The RHA manages its credit risk surrounding cash and short-term investments and investments by dealing solely with reputable banks and financial institutions, and utilizing an investment policy to guide their investment decisions. The RHA invests surplus funds to earn investment income with the objective of maintaining safety of principal and providing adequate liquidity to meet cash flow requirements.

d) Market Risk

Market risk is the risk that changes in market prices, such as foreign exchange rates or interest rates, will affect the RHA's income or the value of its holdings of financial instruments. The objective of market risk management is to control market risk exposures within acceptable parameters while optimizing return on investment

i) Foreign Exchange Risk:

The RHA operates within Canada, but in the normal course of operations is party to transactions denominated in foreign currencies. Foreign exchange risk arises from transactions denominated in a currency other than the Canadian dollar, which is the functional currency of the RHA. The RHA believes that it is not subject to significant foreign exchange risk from its financial instruments.

12. Financial Instruments - continued

ii) Interest Rate Risk:

Interest rate risk is the risk that the fair value of future cash flows or a financial instrument will fluctuate because of changes in the market interest rates.

Financial assets and financial liabilities with variable interest rates expose the RHA to cash flow interest rate risk. The RHA's investments include long-term bonds bearing interest at coupon rates. The RHA's long-term debt outstanding as at March 31, 2015 and 2014 have fixed interest rates.

Although management monitors exposure to interest rate fluctuations, it does not employ any interest rate management policies to counteract interest rate fluctuations.

As at March 31, 2015, had prevailing interest rates increased or decreased by 1%, assuming a parallel shift in the yield curve, with all other variables held constant, the RHA's financial instruments would have decreased or increased by approximately $66,000, (2014 - $45,000) approximately 5% of the fair value of investments (2014 – 4%).

e) Liquidity Risk

Liquidity risk is the risk that the RHA will not be able to meet its financial obligations as they become due.

The RHA manages liquidity risk by continually monitoring actual and forecasted cash flows from operations and anticipated investing and financing activities.

At March 31, 2015 the RHA has an operating cash balance of $9,723,515 (2014 - $9,958,300).

f) Fair Value

The carrying amounts of these financial instruments approximate fair value due to their immediate or short-term nature:

- Cash and short-term investments
- Accounts receivable
- Accounts payable
- Accrued salaries and vacation payable

12. Financial Instruments - continued

The carrying amount of investments approximates their fair value as interest rates are consistent with current market rates.

The fair value of long term debt before the repayment required within one year is $8,816,064 (2014 $10,218,960) and is determined using discounted cash flow analysis based on current incremental borrowing rates for similar borrowing arrangements, net of mortgage subsidies.

g) Short-term Borrowing/Operating Line-of-credit

The RHA has a line-of-credit of $1,000,000 (2014 - $1,000,000) with a floating rate of interest charged at Prime minus .50% which is re-negotiated annually. The line-of-credit is secured by accounts receivable including all grants, revenues and any other forms or sources of payments from the Province of Saskatchewan and any other funding bodies. Total interest paid on the line-of-credit was $0 (2014 - $0).

13. Community Generated Funds

Under the terms of the pre-amalgamation agreement, the RHA has agreed to hold community generated assets in trust. The Board established a separate fund for the assets of each trust. Health corporations formerly held these assets before amalgamating with the Board. The assets are interest bearing with the interest credited to the trust balance. The Authority presently administers $3,516,800 (2014 - $3,519,569) under these agreements.

Each trust fund has a "Trust Advisory Committee" which is appointed by the various towns, villages, hamlets, and rural municipalities served by the pre-amalgamation agency. The trust funds are for the benefit of the ratepayers of the various municipalities and shall be used for health related purposes. The committees have the power to establish rules and procedures and the majority decision of the committees shall be binding upon the RHA with respect to any use of the trust fund.

14. Energy Performance Contract

Energy performance contracting is a unique program that allows the RHA to implement facility improvements, reduces energy costs, improve health and comfort conditions while contributing to the province's environmental objectives. *SaskPower Energy Solutions* performed extensive research to establish a baseline of annual cost savings they guarantee as part of this project. The project is expected to provide utility cost savings that will pay for the cost and financing of this project within an established time frame. Any additional savings are calculated and verified by methods established in the contract and are applied to the loan. Kelsey Trail Regional Health Authority entered into a guaranteed energy performance savings contract with *SaskPower Energy Solutions Company.*

14. Energy Performance Contract - continued

The total cost of the energy performance contract is $4,861,669. As at March 31, 2015, construction costs of $4,785,198 (2014 - $4,785,198) have been financed through a $4,861,669 long-term debt loan with a balance of $3,892,326 outstanding (2014 - $4,092,912), which bears interest at a rate of 5.33%. The long-term debt is amortized over a period of 18.5 years.

Results of the energy renewal project since its inception are:

	2015	Prior Years	Total
Estimated Utility Savings	394,983	1,281,048	1,676,031
Interest Costs	213,299	1,059,236	1,272,535

15. Collective Bargaining Agreements

The Saskatchewan Government Employees Union (SGEU) contract is in effect until March 31, 2017. The Saskatchewan Union of Nurses (SUN) contract expired March 31, 2014 and the Health Sciences Association of Saskatchewan (HSAS) contract expired March 31, 2013. Negotiations are in the early stages and an estimate of the settlements is not determinable at this time.

16. Pay for Performance

As part of government-wide fiscal restraint measures, the pay for performance compensation plan has been suspended for the 2014-15 and 2015-16 fiscal years. This compensation plan was introduced in April 2011 and allowed senior employees to be eligible to earn lump sum performance adjustments of up to 110% of their base salary. In prior years, senior employees were paid 90% of current base salary and lump sum performance adjustments related to the previous year. Due to the suspension of the pay for performance compensation plan, senior employees will receive 100% of their base salary for 2014-15 and 2015-16.

17. Changes in Accounting Policy

Effective April 1, 2014 the RHA adopted the new PS 3260 Liability for Contaminated Sites standard. This section establishes standards on how to account for and report a liability associated with the remediation of contaminated sites. Contaminated sites are the result of contamination being introduced into air, soil, water or sediment of a chemical, organic or radioactive material or live organism that exceeds the maximum acceptable concentrations under an environmental standard. This standard only applies to operations that are no longer in productive use, or where an expected event occurs that has caused contamination. A liability for remediation of contaminated sites is recognized when all of the following criteria are met:

- an environmental standard exists;
- contamination exceeds the environmental standard;
- the RHA:

17. Changes in Accounting Policy - continued

- is directly responsible; or
- accepts responsibility;

- the RHA expects that future economic benefits will be given up; and
- a reasonable estimate of the amount can be made.

The adoption of the new PS 3260 standard has not resulted in any changes to the measurement and recognition of liabilities in the RHA's 2015 financial statements.

18. Contingent Liability

There is a possibility of a future compensation liability from a union grievance; the amount of any actual costs is unknown at this time.

The long term care facility, Sasko Park Lodge, was closed on March 17th, 2015. The authority is in the process of decommissioning the property; the amount of any costs is unknown at this time.

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXPENSES BY OBJECT
For the Year Ended March 31, 2015

Schedule 1

	Budget 2015	Actual 2015	Actual 2014
Operating:			
Advertising & public relations	$ 83,180	$ 45,507	$ 165,416
Board costs	117,210	93,044	126,846
Compensation - benefits	14,749,103	15,047,774	14,383,363
Compensation - employee future benefits	-	(20,900)	(35,700)
Compensation - salaries	75,742,757	75,480,735	76,195,144
Continuing education fees & materials	306,682	258,655	225,642
Contracted-out services - Other	297,114	238,740	242,371
Diagnostic imaging supplies	24,300	8,809	16,488
Dietary supplies	140,838	129,592	134,903
Drugs	629,619	678,704	626,741
Food	1,703,507	1,758,434	1,671,619
Grants to ambulance services	2,876,889	2,876,889	2,790,582
Grants to health care organizations & affiliates	817,932	782,570	776,163
Housekeeping & laundry supplies	321,976	357,090	311,018
Information technology contracts	959,156	777,147	953,343
Insurance	234,500	243,489	225,427
Interest	218,899	221,959	230,029
Laboratory supplies	1,232,311	1,047,077	1,122,856
Medical & surgical supplies	2,682,060	2,728,894	2,528,617
Medical remuneration & benefits	10,780,029	10,992,108	10,693,693
Meetings	98,251	99,271	47,650
Office supplies & other office costs	414,830	422,955	348,565
Other	390,588	522,606	407,984
Professional fees	930,345	891,191	881,895
Prosthetics	-	-	-
Purchased salaries	618,345	1,008,496	694,604
Rent/lease/purchase costs	1,401,602	1,317,807	1,440,900
Repairs & maintenance	1,655,378	1,644,772	1,594,563
Supplies - Other	354,411	417,376	384,303
Therapeutic supplies	-	-	-
Travel	1,190,921	1,210,605	1,127,944
Utilities	2,374,863	2,420,549	2,575,473
Total Operating Expenses	$ 123,347,596	$ 123,701,945	$ 122,888,442
Restricted:			
Amortization		$ 4,910,301	$ 4,053,377
Loss/(Gain) on disposal of fixed assets		-	-
Mortgage Interest Expense		209,310	257,552
Other		29,135	100,044
		$ 5,148,746	$ 4,410,973

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF CONSOLIDATED INVESTMENTS
As at March 31, 2015

Schedule 2

		Fair Value	Maturity	Effective Rate	Coupon Rate
Restricted Investments*					
Cash and Short Term					
Chequing and Savings:					
Cornerstone Credit Union - Tisdale	$	6,725,014			
Diamond North Credit Union		43,271			
	$	6,768,285			
Term Deposits:					
		-			
	$	-			
Total Cash & Short Term Investments	$	6,768,285			
Long Term					
		-			
Total Long Term Investments	$	-			
Total Restricted Investments	$	6,768,285			
Unrestricted Investments					
Cash and Short Term					
Cash on Hand	$	6,800			
Cornerstone Credit Union - Tisdale		8,947,161			
Affinity Credit Union - Melfort		30,217			
Diamond North Credit Union		33,859			
Affinity Credit Union - Hudson Bay		13,127			
Porcupine Credit Union		3,558			
Accent Credit Union - Kelvington		4,307			
Cornerstone Credit Union - Short Term		327			
Total Cash & Short Term Investments	$	9,039,356			
Long Term					
Bonds	$	1,280,293	Various	4.89%	Various
Total Long Term Investments	$	1,280,293			
Total Unrestricted Investments	$	10,319,649			
Total Investments	$	17,087,934			
Restricted & Unrestricted Totals:					
Total Cash & Short Term	$	15,807,641			
Total Long Term		1,280,293			
Total Investments	$	17,087,934			

* Restricted Investments consist of:
  - Community generated funds transferred to the RHA and held in the Community Trust Fund (Schedule 3); and
  - Replacement reserves maintained under mortgage agreements with Canada Mortgage and Housing Corporation (CMHC) and/or Saskatchewan Housing Corporation (an agency of the Department of Community Resources and Employment) (SHC) held in the Capital Fund (Schedule 4).

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF EXTERNALLY RESTRICTED FUNDS
For the Year Ended March 31, 2015

Schedule 3

COMMUNITY TRUST FUND EQUITY

Trust Name	Balance Beginning of Year	Investment & Other Revenue	Donation	Expenses / Transfers	Capital Expenses	Balance End of Year
Community Services	$ 114,748	$ 1,597	$ 3,950	$ -	$ (3,705)	$ 116,590
Edith Campbell Bursary	26,141	373	2,500	-	-	29,014
Hudson Bay Health Care Facility	234,680	3,195	47,561	(2,735)	(25,000)	257,701
Kelvindell Lodge	120,322	1,661	7,373	(6,649)	-	122,707
Kelvington Hospital	148,486	2,070	4,520	-	-	155,076
Newmarket Place	443,999	6,559	42,628	(160,678)	-	332,508
Pam Worley Bursary	632	9	-	-	-	641
Porcupine Plain Hospital	267,224	3,706	10,775	(5,692)	-	276,013
Ralston Medical Research	520,820	7,188	-	(3,568)	-	524,440
Red Deer Nursing Home	65,409	848	4,791	(2,276)	(8,362)	60,410
Rose Valley Health Centre	82,535	1,142	20	(25)	-	83,672
Tisdale Hospital	1,375,675	19,369	30,766	-	(8,320)	1,417,490
Tisdale Hospital - Dialysis Unit	118,897	1,766	19,875	-	-	140,538
Total Community Trust Fund	$ 3,519,568	$ 49,483	$ 174,759	$ (181,623)	$ (45,387)	$ 3,516,800

CAPITAL FUND

	Balance Beginning of Year	Investment & Other Income	Capital Grant Funding	Expenses / Transfers	Capital Expenses	Balance End of Year
Sask Health Initiatives						
Ministry of Health - Block Funding	$ 244,479	$ -	$ 527,500	$ -	$ (643,823)	$ 128,156
Ministry of Health - Capital Equipment	411,661	-	410,000	-	(462,637)	359,024
Ministry of Health - Capital Projects	312,196	529,014	1,221,884	418,326	(2,407,940)	73,480
Ministry of Health - CT Project	429,400	-	-	-	-	429,400
Ministry of Health - Radiology Equipment	661,491	-	-	-	(40,775)	620,716
Ministry of Health - Safety and Surgical	212,348	-	-	-	(57,721)	154,627
Total Sask Health	$ 2,271,575	$ 529,014	$ 2,159,384	$ 418,326	$ (3,612,896)	$ 1,765,403
Non Sask Health Initiatives						
Other	99,153	60,307	-	-	(102,261)	57,199
Total Non Sask Health Initiatives	$ 99,153	$ 60,307	$ -	$ -	$ (102,261)	$ 57,199
Total Capital Fund	$ 2,370,728	$ 589,321	$ 2,159,384	$ 418,326	$ (3,715,157)	$ 1,822,602
TOTAL EXTERNALLY RESTRICTED FUNDS	$ 5,890,296	$ 638,804	$ 2,334,143	$ 236,703	$ (3,760,544)	$ 5,339,402

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULE OF INTERNALLY RESTRICTED FUND BALANCES
For the Year Ended March 31, 2015

Schedule 4

	Balance, beginning of year	Investment income allocated	Annual allocation from unrestricted fund	Transfer to unrestricted fund (expenses)	Capital Expenses	Balance, end of year
Capital						
Replacement Reserves						
Arborfield Special Care Home	$ 131,820	$ 1,824	$ -	$ -	$ -	$ 133,644
Chateau Providence	60,871	853	7,750	-	-	69,474
Kelvindell Lodge	62,416	841	8,043	-	(4,897)	66,403
Newmarket Manor	218,770	1,955	18,000	-	(153,314)	85,411
Pineview Lodge	16,066	225	11,254	-	-	27,545
Red Deer Nursing Home	53,882	750	-	-	-	54,632
Total Replacement Reserves	$ 543,825	$ 6,448	$ 45,047	$ -	$ (158,211)	$ 437,109
Other Internally Restricted Funds						
Activities - Arborfield Special Care Home	12,171	5,302	-	(4,975)	-	12,498
Activities - Carrot River	21,244	11,248	-	(3,214)	-	29,278
Ambulances	153,060	1,532	50,000	-	(136,873)	67,719
Capital	496,541	343,077	684,159	-	(654,408)	869,369
Cumberland House Health Centre	33,132	464	7,500	-	-	41,096
Cumberland House Home Care	22,479	150	-	-	(20,595)	2,034
Hudson Bay Health Care Facility	55,507	681	5,080	-	(21,593)	39,675
Newmarket Manor - Floor Account	254,445	3,203	-	(257,648)	-	-
Nirvana Pioneer Villa	70,026	915	12,000	-	(19,350)	63,591
Palliative Home Care	1,477	19	-		-	1,496
Parkland	207,777	2,765	20,000	-	(21,158)	209,384
Pasquia Special Care Home	56,188	787	5,800	-	-	62,775
Rose Valley Health Centre	75,649	1,040	8,111	-	(2,975)	81,825
Sasko Park Lodge	12,030	169	-	-	-	12,199
Tisdale Joint Use Facility	5,597	77	290	-	-	5,964
Total Capital	$ 2,021,148	$ 377,877	$ 837,987	$ (265,837)	$ (1,035,163)	$ 1,936,012
Operating						
Other Internally Restricted Funds	$ -	$ -	$ -	$ -	$ -	$ -
Total Operating	$ -	$ -	$ -	$ -	$ -	$ -
Total Internally Restricted Funds	$ 2,021,148	$ 377,877	$ 837,987	$ (265,837)	$ (1,035,163)	$ 1,936,012

KELSEY TRAIL REGIONAL HEALTH AUTHORITY
SCHEDULES OF
BOARD MEMBER REMUNERATION
for the year ended March 31, 2015

Schedule 5(a)

RHA MEMBERS	RETAINER	PER DIEM	TRAVEL TIME EXPENSES	TRAVEL AND SUSTENANCE EXPENSES	OTHER EXPENSES	CPP	2015 TOTAL	2014 TOTAL
Chairperson								
Rennie Harper	9,960	25,714	9,435	-	-	-	45,109	59,005
Board Member								
Clarence Hendrickson	-	9,429	5,703	-	-	-	15,132	19,319
Darrell Guy	-	4,888	2,825	-	-	-	7,713	9,801
Dennis Koch	-	3,763	895	-	-	117	4,775	9,895
Frank Garchinski	-	3,615	1,424	-	-	-	5,039	5,885
Gordon Cresswell	-	2,313	302	-	-	-	2,615	7,144
Kathleen Bedard	-	2,777	898	-	-	-	3,675	6,730
Nancy Steinbachs	-	2,825	1,535	-	-	-	4,360	7,096
Richard Radom	-	3,849	1,498	-	-	146	5,493	5,962
Vacant Position	-	-	-	-	-	-	-	-
TOTAL	9,960	59,173	24,515	-	-	263	93,911	130,837

SENIOR MANAGEMENT SALARIES, BENEFITS, ALLOWANCES, AND SEVERANCE

for the year ended March 31, 2015

Schedule 5 (b)

	2015							2014		
Senior Employees	**Salaries[1]**	**Vacation Payout[1]**	**Sub-total (Total Salaries)**	**Benefits and Allowances[2]**	**Sub-total**	**Severance Amount**	**Total**	**Salaries, Benefits & Allowances[1,2]**	**Severance**	**Total**
Glen Kozak, CEO[3]	$ 27,572	$ -	$ 27,572	$ -	$ 27,572	$ -	27,572	$ 272,726	$ -	$ 272,726
Shane Merriman, CEO[4]	$ 290,253	$ -	$ 290,253	$ 66	$ 290,319	$ -	290,319			
Senior Positions:										
Pam McKay	249,808	-	249,808	866	$ 250,674	-	250,674	238,308	-	238,308
VP Institutional Health Care										
Shane Merriman[4]	-	-	-	-	$ -	-	-	191,266	-	191,266
VP Corporate Services										
Shane Merriman[5]	-	-	-	-	$ -	-	-	66,479	-	66,479
VP Corporate Services & Acting COO										
Connie Glover[6]	130,741	-	130,741	55	$ 130,796	-	130,796			
VP Corporate Service										
Richard Peters[7]	42,317	-	42,317	253	$ 42,570	-	42,570	139,860	-	139,860
VP Community & Primary Health Care										
Lyle Bauman	128,474	-	128,474	722	$ 129,196	-	129,196			
VP Health, Safety & Culture										
Dr. Jordan Wingate	164,628	-	164,628	3,600	$ 168,228	-	168,228	153,942		153,942
VP Medical Services & Chief of Staff										
Total	$ 1,033,793	$ -	$ 1,033,793	$ 5,562	$ 1,039,355	$ -	$ 1,039,355	$ 1,062,581	$ -	$ 1,062,581

1. Salaries include regular base pay, overtime, honoraria, sick leave, vacation leave, and merit or performance pay, lumpsum payments, and any other direct cash remuneration. The pay for performance compensation plan has been suspended for the 2014-15 and 2015-16 fiscal years. Senior employee will receive 100% of their base salary for 2014-15 and 2015-16. For further details refer to Note 16 - Pay for Performance.

2. Benefits and Allowances include the employer's share of amounts paid for the employees' benefits and allowances that are taxable to the employee. This includes taxable: professional development, education for personal interest, non-accountable relocation benefits, personal use of an automobile, cell-phone, computer, etc. As well as any other taxable benefits.

3. Interim position May 14, 2012 to July 17, 2014

4. Retired December 31, 2013

5. Acting COO position began December 13, 2013

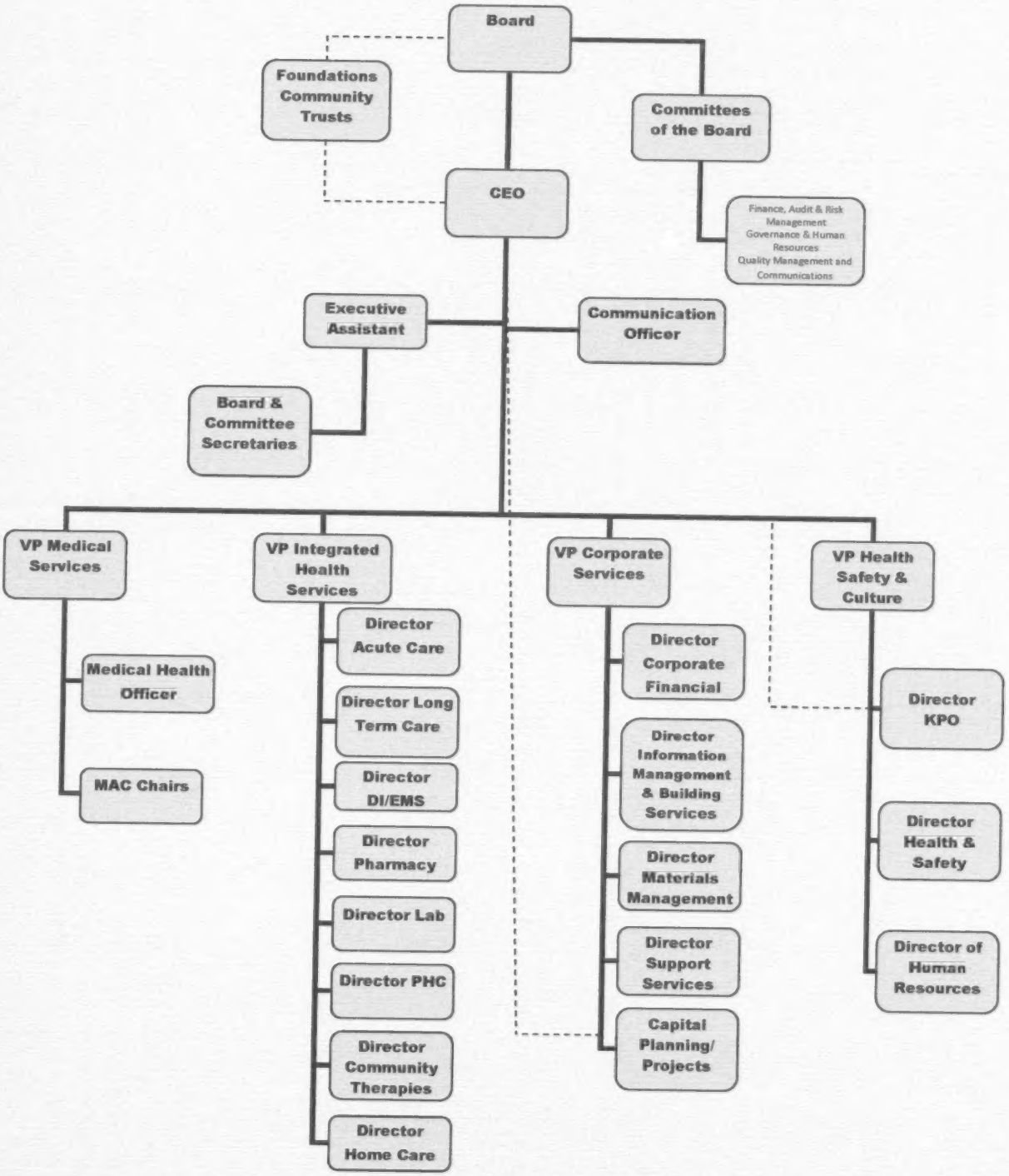
6. Position began April 1, 2014

7. Position began June 1, 2014

8. Position from April 1, 2013 to December 12, 2013

Appendices

2014-15 Organizational Chart



KELSEY TRAIL REGIONAL HEALTH AUTHORITY
PAYEE DISCLOSURE LIST
For the Year Ended March 31, 2014

As part of government's commitment to accountability and transparency, the Ministry of Health and Regional Health Authorities disclose payments of $50,000 or greater made to individuals, affiliates and other organizations during the fiscal year. These payments include salaries, contracts, transfers, supply and service purchases and other expenditures.

Listed are individuals who received payments for salaries, wages, honorariums, etc. which total $50,000 or more

Personal Services

Aasen, Corey	$63,100.10	Barlow, Linda	$122,594.31
Aasen, Tammy	81,041.47	Barrie, Amber	100,413.40
Aasen, Ward	67,496.28	Batiuk, Carlina	50,735.21
Adames, Oralee	83,281.11	Bayne, Bonny	52,400.93
Agur, Jennifer	52,415.63	Bear, Samantha	58,312.02
Agustin, May	53,778.76	Beaulieu, Sharon	92,429.27
Alexander, Laura	79,550.67	Becker, Kaye	65,641.70
Anderson, Christie	103,717.90	Becker, Peggy	50,290.13
Anderson, Penny	88,798.51	Bedard, Tracy	91,842.16
Andrus, Angela	84,737.27	Bednarz, Amanda	76,176.90
Anstey Teichroeb, Kelly	72,161.58	Beecher, Clint	78,255.56
Argent, Maryann	50,446.62	Bergren, Dorothy	106,186.61
Arneson, Anna	88,457.02	Bertrand, Marilyn	65,310.28
Assie, Ramona	109,707.96	Betthel, Kim	50,085.41
Atkings, Deborah	88,294.11	Bharot, Jaspreet	88,112.04
Atkinson, Lorette	62,582.77	Bigelow, Sharyl	64,880.09
Audette, Debra	62,251.36	Bischoff, Carrie	106,779.93
Bagnall, Charlott	57,699.67	Bittman, Lyle	148,680.69
Bailey, Trenna	69,133.85	Bitzer, Denise	103,246.11
Ballendine, Laurie	60,701.73	Black, Joan	101,785.69
Baptist, Farrah	72,673.81	Bohachewsky, Kathy	51,344.04
Baraniski, Brenda	50,143.37	Bohaychuk, Vickie	68,371.71
Barker, Judy	51,881.90	Bonsan, Roxane	90,031.58

Borsa, Shannon	74,101.06	Chaboyer, Sheila	70,834.34
Boughen, Janice	70,578.85	Chapman, Jeannine	98,584.84
Bouvier, Gisele	57,039.89	Charko, Jessie	78,037.99
Boxall, Lia	142,685.91	Chatfield, Patty	74,396.35
Braaten, Lynda	79,479.43	Chorney, Jessica	73,759.87
Bradley, Margaret	94,938.20	Christianson, Leslie	77,604.79
Bradshaw, Katherine	68,390.27	Chrusch, Maureen	99,455.26
Bradshaw, Rochelle	50,095.83	Chute Bodvarson, Bobbi	81,033.62
Brakstad, Terry	73,256.12	Clark, Thomas	86,270.58
Brann, Amy	89,479.19	Clarke, Janice	93,780.81
Bronner, Tanis	67,574.92	Clarke, Leeann	83,281.15
Brooks, Leslie	58,665.61	Claypool, Renee	86,542.26
Brothwell, Linda	112,415.31	Clerigo, Desiree	63,079.63
Brown, Chase	65,117.69	Clunie, Rhonda	52,324.32
Brown, Diane	54,819.51	Code, Jacquelin	76,354.63
Brown, Tammy	67,112.70	Cole, Betty	87,907.87
Bryson, Dennis	91,140.79	Cole, Camille	50,537.76
Buhler, Jessie	101,715.83	Collins, Beverly	56,342.97
Burghardt, Shelley	66,418.83	Connors, Ella	55,055.44
Burtnick, Mackenzie	50,739.16	Cosh, Deena	55,074.79
Burton, Violet	91,523.20	Cressman, Donna	50,447.17
Buyaki, Peggy	64,263.89	Cressman, Trudy	82,432.87
Cal, Shelly	169,867.53	Crickett, Donna	98,774.56
Campbell, Lavinia	53,166.79	Cross, Danielle	90,942.92
Campbell, Quentin	56,017.58	Cross, Debbie	62,163.83
Campbell, Vivian	119,863.81	Currie, Debra	68,367.65
Carfantan, Dana	76,905.34	Curry, Brooke	104,196.91
Carlson, Sandra	94,151.75	Curry, Meghan	65,301.61
Carolus, Andrew	83,779.88	Dagg, Arlene	71,499.39
Caron, Christine	50,185.50	Dahl, Sherry	97,042.98
Carswell, Kathryn	90,083.18	Dalziel, Joan	64,812.71
Casavant, Janice	77,494.24	Daoust, Roxane	78,130.34
Chabot, Catherine	84,318.81	Davies, Bonita	55,042.47

Davis, Andrea	55,067.10	Espenant, Rodney	100,575.04
Day, Karen	102,062.97	Evans, Courtney	60,515.66
De Haan, Sonya	95,244.07	Ewen, Linda	74,959.87
Dean, Melody	88,754.80	Ewen, Sandy	76,400.27
Delaet, Erin	79,518.91	Fagnou, BettyLou	93,983.55
Delwisch, Sandra	70,997.26	Fannon, Lee Ann	85,843.55
Demarsh, Terry	91,773.75	Farber, Tracy	112,846.02
Derenowski, Carmen	56,187.72	Farncombe, Tannis	50,858.66
Dierker, Christine	95,633.48	Farrow, Tracy	62,097.82
Diller, Ronald	97,436.39	Fawcett, Jeffrey	88,354.92
Dobrinski, Barb	101,433.56	Fawcett, Stephanie	91,514.67
Dobson, Tina	73,593.90	Fecke, Beatrice	53,865.11
Dolezsar, Karen	50,498.83	Fehr, Debbie	50,189.78
Donald, Ronda	112,415.27	Fellman, Leanne	99,551.99
Doucette, Delvena	83,137.15	Ferguson, Terri Lynn	85,980.09
Doucette, Natalie	102,730.47	Fernwalt, Donna	51,618.68
Douslin, Sharon	78,544.90	Ferre, Arien	74,565.59
Drake, Chantelle	91,140.81	Fidyk, Melanie	101,630.50
Draude, Pattie	92,325.94	Findlay, Diana	50,587.75
Drotar, Lynnette	71,737.62	Firman Depeel, Christine	78,840.66
Duerksen, Loretta	81,723.24	Flamand, Sonia	69,002.64
Dumitrascu, Maria	60,941.24	Flodell, Norma	51,890.61
Dyck, Stephanie	65,576.96	Folden, Deanna	73,207.25
Edstrom, Darlene	93,063.50	Ford, Kelly	77,665.39
Edwards, Shelly	95,483.08	Fortin, Wendy	60,156.92
Emro, Donna	51,024.85	Foster, MaryAnne	99,166.84
Enge, Terry	76,983.87	Fountain, Kyla	82,695.35
Ens, Cheryl	69,756.27	Francais, Maureen	60,700.62
Ens, Evan	83,281.08	Franke, Vera	63,776.54
Epino-Lao, Adelfa	57,498.94	Franklin, Judy	68,549.74
Erickson, Bonnie	55,315.36	Franklin, Karri	112,415.31
Ericson, Rayleen	56,115.54	Freedman, Allison	55,552.00
Ernst, RaeAnn	69,239.58	Friesen, Dwayne	85,515.17

Frisky, Sharon	112,556.59	Hancock, Tracie	65,264.60
Fritshaw, Brittany	55,245.77	Harbicht, Faye	83,281.11
Froese, Margaret	57,842.69	Harrison, Karen	53,350.93
Fullerton, Natasha	73,597.98	Hart, Sandra	56,678.30
Funk, Rebecca	100,948.27	Haugo, Aline	82,446.75
Gallays, Paulette	77,737.33	Hayduk, Michael	84,080.20
Galucan, Carolyn	103,109.39	Hayes, Wendy	60,080.60
Garchinski, Kimberley	102,194.55	Hayworth, Beverly	73,687.06
Garcia, Ryan	51,880.37	Heatherington, Breann	64,474.93
Garland, Stephanie	90,089.94	Hedin, Cody	78,566.17
Geck, Denise	102,352.23	Hedin, Kimberly	56,969.16
Genik, Heather	102,236.31	Hemingson, Linda	100,169.75
George, Myrna	71,326.99	Henderson, Elaine	95,884.71
Gessner, Mary	59,631.09	Hermus, Joan	76,549.91
Getachew, Eyoueal	96,528.23	Heron, Maureen	81,912.45
Glaves, Connie	150,948.08	Hewitt, Anna Dawn	113,621.06
Glister, Sherrie	74,456.81	Hiebert, Gillian	84,066.01
Gooliaff, Dolores	75,690.42	Hiebert, Jessi	63,618.14
Gordon, Ardis	76,462.09	Hiebert, Kari	101,406.96
Gordon, Jessica	93,707.94	Hildebrand, Leah	54,035.44
Gray, Raymond	58,630.76	Hirsch, Jana	86,900.86
Gray, Shawna	63,599.59	Hobbins, Tim	110,491.25
Gudnason, Douglas	105,796.80	Hoffus, Diane	83,338.85
Guillet, Val	50,888.45	Hoffus, Marianna	76,098.51
Gustafson, Joanne	50,601.95	Honoway, Renee	62,787.48
Hage, Barbara	73,459.98	Honoway, Sean	61,213.53
Hainstock, Donna	83,281.14	Hosaluk, Jo Elle	53,472.60
Hall, Jeanine	52,000.90	Howse, Wendy	90,836.16
Hall, Judy	58,344.64	Hoyt, Catherine	56,534.63
Hall, Michelle	76,446.78	Hrebeniuk, Renee	60,688.06
Halvorsen, Elaine	102,194.55	Hrenkiw, Collette	62,501.71
Hampton, Bonnie	106,163.11	Hrychuk, Michelle	73,314.09
Hancock, Jason	76,340.74	Hudak, Darlene	76,896.50

Huff, Ashley	65,367.34	Kovach, Tammy	105,180.01
Hughes, Tracy	98,586.90	Kovacs, Coral	103,909.52
Hunt, Shirley	92,429.26	Kowal, Joell	74,456.83
Hunt, Stacey	94,022.94	Kowal, Louise	113,066.32
Isberg, Kathie	55,483.44	Kowalyk, Leah	58,161.09
Ives, Brenda	82,815.64	Kozun, Tamara	68,360.32
Jackson, Vanessa	70,814.44	Kuhberg, Sylvia	75,414.17
Janzen, Crystal	66,382.41	Kuras, Crystal	59,300.35
Jeffrey, Audrey	54,540.08	Kurtz, Wanda	50,344.77
Johns, Sheryl	50,834.64	Kutnikoff, Sarah	83,207.79
Johnson, Bonnie	124,920.18	Kwasney, Laurie	105,297.64
Johnson, Marilyn	57,202.94	Lalla, James	57,051.16
Jones, Judy	72,295.93	Lalonde, Deborah	95,167.33
Jones, Kama	62,611.31	Lamont, Audrey	76,040.83
Kajner, Judy	54,941.70	Larsen, Angela	66,969.22
Kajner, Neelie	60,681.05	Larson, Janelle	82,723.95
Kapeller, Eliza	71,301.92	Larson, Leonila	51,220.02
Keeping, Ruth	52,826.54	Lauinger, Elaine	53,689.48
Khan, Mohammad	223,789.23	Le Bras, Doreen	78,029.17
Kiefer, Marilyn	112,853.39	Le Grand, Mildred	57,026.14
Kinch, Derek	59,117.29	Lebel, Diane	51,173.96
King, Elaine	52,472.29	Lechler, Pamela	65,947.54
Kirk, Wendy	69,467.78	Lee, Roxanne	91,128.27
Kirkland, Sherrie	84,180.12	Lee, Sandra	50,091.74
Kiteley, Wanda	70,929.95	Leek, Brenda	78,570.74
Klassen, Linda	68,770.82	Leepart, Beverly	59,912.46
Kleiboer, Sharon	72,071.62	Lindsay, Alisa	91,976.34
Knelson, Arlie	52,720.14	Lindsay, Joanne	72,127.86
Kolodinsky, Charleen	57,026.20	Lindsay, Lynda	83,496.74
Kolybaba, Amanda	78,741.51	Lindsay, Maureen	73,634.27
Koroll, Jarod	82,474.54	Lipka, Sharon	54,459.46
Kosokowsky, Louise	93,716.93	Little, David	83,281.18
Kostiew, Nikki	93,238.00	Lockie, Laury	50,706.88

Logan, Kim	102,023.54	McFarlane, Lana	75,106.35
Lopez, Christian	54,665.29	McInnis, Magdalene	78,075.46
Love, Nicolette	97,342.94	McKay, Pamela	249,807.76
Lueken, Linda	102,856.46	McKee, Kara	61,547.41
Lukan, Linda	50,434.29	McKenzie, Trisha	53,111.57
Lummerding, Michael	94,971.70	McKnight, Heather	68,448.70
Lundy, Jody	81,400.51	McLaren, Terri	88,130.19
Lutz, Tammy	64,244.72	McLean, Cheryl	56,444.47
MacDonald, Judy	66,209.97	McRae, Sherrie	59,250.61
Mackie, Carmen	83,774.79	McWillie, Greg	130,482.29
MacNaughton, Angela	63,193.13	Melrose, Beverly	79,282.16
Mahon, Sherry	91,611.00	Mennie, Maxine	54,217.07
Mahussier, Wanda	88,373.93	Menzies, Annette	84,042.43
Major, Lisa	121,012.81	Merriman, Shane	290,253.04
Malhi, Sukhwinde	55,967.67	Messner, Janice	106,545.93
Mamer, Francoise	116,497.86	Mevel Degerness, Nadine	112,415.30
Manavalan Antony, Reji	82,971.46	Meyer, Kathleen	104,532.89
Mansiere, Shaye	74,926.68	Meyers, Candace	81,086.54
Marban, Charlemag	131,307.73	Meyers, Stacey	79,411.93
Marshak, Audrey	60,075.32	Miller, Heather	92,429.27
Martens, Heather	72,593.55	Miller, Margaret	90,646.63
Martens, Lesley	67,102.63	Misskey, Lisa	96,591.74
Martin, Kade	74,711.55	Mitchell, Trent	138,821.53
Martin, Pauline	91,802.83	Moffatt, Glenda	51,071.62
Mathesonboe, Dana	52,442.31	Molnar, Kevin	74,183.69
Matiasz, Tammy	72,039.18	Molnar, Pamela	95,261.65
McCleary, Angela	76,667.60	Moneta, Shari	71,145.74
McCleary, Patricia	99,179.08	Montes, Sharon	52,748.92
McCorriston, Elizabeth	53,423.32	Moore, Crystal	97,666.05
McCreadie, Stacey	84,955.39	Moulton, Tanya	98,287.72
McCuaig, Chester	105,270.68	Musselman, Leanne	78,977.21
McEwan, David	55,569.00	Mutimer, Candice	51,562.38
McEwen, Stacie	55,024.47	Naber, Colleen	105,326.91

Nagano, Marlene	125,795.64	Ottmann, Cindy	50,678.94
Nagano, Myla	142,184.75	Pappenfoot, Christine	92,282.81
Nagy, Garnet	93,025.01	Parlee, Tammy	102,194.55
Nagy, Karen	51,849.34	Paskell, Darla	62,464.09
Nagy, Stacey	75,213.97	Patenaude, Elaine	80,326.07
Nakonieczny, Ada	64,853.46	Patenaude, Judy	82,420.51
Nakonieczny, Lerissa	55,959.99	Patterson, Dale	71,451.99
Nanaquewetung, Lesley	77,327.75	Patterson, Trudy	55,459.05
Neigel, Cindy	82,756.86	Paulo, Desiree	50,632.02
Neigel, Sarah	92,429.28	Penner, Andrea	72,034.08
Neiszner, Tanya	102,194.55	Penner, Joanne	64,147.95
Nelson, Michele	76,386.07	Penner, Shelley	64,727.78
Neu, Monica	77,256.48	Perrault, Linda	102,611.19
Neufeld, Anjie	82,753.67	Perrault, Roxanne	101,615.85
Newbery, Donna	55,109.96	Perrault, Sophie	56,815.67
Nickel, Rhonda	114,611.52	Perron, Stacey	69,612.71
Nickeson, Carla	50,001.10	Peters, Richard	136,186.41
Nicklefork, Ryan	72,148.57	Peters, Sharon	102,194.55
Nontell, Margaret	64,880.09	Peterson, Linda	92,429.27
Nordmarken, Kimberly	56,480.99	Peterson, Sheryn	74,189.01
Nordstrom, Jeanne	79,749.09	Philipation, Ryan	99,634.07
Nordstrom, Ruth	51,785.54	Phillips, Angela	57,026.15
Nyirenda, Julien	100,386.00	Pickett, Laura	72,629.20
O'Flanagan, Cheryl	70,029.66	Pohl, Christine	112,415.31
O'Flanagan, Linda	54,692.13	Pohl, Curtis	89,040.87
Oftebro, Marilyn	73,725.18	Pohl, Jennifer	74,477.89
Olafson, Sharon	50,348.54	Pongco, Rachelle	64,364.39
Olan, Megan	59,247.65	Pratt, Laureen	79,369.76
Ollinger, Monique	62,917.30	Prefontaine, Holly	56,914.27
Olsen, Crystal	68,371.40	Prince, Charlaine	50,065.01
Olson, Dinah	77,394.40	Puno, Mary Rose	51,762.23
Olson, Patricia	116,304.26	Radloff, Jennifer	71,459.10
Orobko, Laura	65,423.29	Ralph, Diane	54,669.20

Randall, Allix	66,776.48	Schmaltz, Carlene	95,676.66
Ratcliffe, Peggy	83,281.16	Schmitt, Joyce	68,478.85
Ratzlaff, Lyndsay	55,303.13	Schrader, Audrey	52,256.36
Reed, Lorry	97,216.57	Scutchings, Jodie	81,554.01
Reid, Barbara	85,794.04	Seiferling, Sheila	109,515.59
Reid, Jill	95,231.32	Senecal, Jean	94,556.36
Reyes, Jennifer	51,643.31	Serhan, Debbie	74,015.11
Riemer, Christina	92,753.30	Settee, Amy	60,426.63
Robertson, Rita	81,779.74	Shearer, Connie	91,705.78
Robin, Rosanne	51,759.39	Shreve, Lisa	80,617.85
Rogalski, Leanne	56,590.11	Siddons, Sandra	57,026.20
Rogers, Candace	75,625.30	Simoneau, Renee	120,495.67
Rogers, Trent	52,417.24	Simonson, Wendy	62,925.69
Rollo, Xander Lyn	65,662.42	Skilliter, Dianne	95,388.25
Romaniuk, Trina	87,265.99	Slobodzian, Fred	119,863.81
Romanow, Jodi	102,194.55	Smears, Wanda	76,008.91
Rosas, Joy Basil	88,543.31	Smith, Debbie	67,468.95
Rosencrans, Randi	89,361.72	Smith, Diane	86,288.73
Rudachyk, Betty	60,378.84	Sochaski, Linda	62,048.06
Rudy, Tara	112,261.98	Solberg, Lisa	60,104.88
Rudychuk, Margaret	102,210.24	Solsten, Julie	90,134.69
Rutherford, Ann Marie	50,058.40	Soonias, Myrna	64,880.09
Rutherford, Shelley	78,051.08	Sorestad, Tracy	62,791.78
Ryhorchuk, Mabel	90,114.48	Soulier, Avalene	87,199.77
Sales, Josie	98,900.83	Sprackman, Michelle	102,194.56
Samida, Lorie	78,164.83	Spratt, Coralie	61,199.96
Sauer, Teresa	57,045.78	Stadnek, Sonja	82,571.29
Scarf, Jeannette	98,735.10	Stensrud, Colleen	135,332.80
Scheidl, Carol	104,644.51	Stevenson, Barbara	99,787.37
Scheidl, Leonard	92,698.78	Stevenson, Cheryl	85,417.96
Schell, Wendy	93,573.28	Stevenson, Kathleen	95,763.78
Scheller, Lenora	52,651.71	Stewart, Geoff	71,730.68
Schidlowsky, Patti	57,256.93	Stone, Carol	51,198.22

Street, Faye	95,822.23	Van Veen, Signey	51,826.70
Streeton, Patricia	94,531.49	VanCamp, Jackie	102,390.32
Strnad, Amanda	77,146.17	Vandertweel, Barbara	53,264.68
Stroeder, Kellie	112,415.26	Vandeveen, Gloria	83,264.14
Stroeder, Kyle	66,160.22	Verklan, Louise	101,803.00
Styan, Cathy	64,880.09	Wall, Christa	64,880.09
Sullivan, Norinne	92,192.57	Wallington, Julia	59,098.14
Sundelin, Jacquelin	65,092.59	Walter, Darin	143,247.92
Swider, Darcy	56,528.39	Warkentin, Ruth	57,562.79
Syrenne, Sharon	71,546.86	Warner, Bessie	112,415.27
Szucs, Denise	59,987.99	Warriner, Valerie	128,857.89
Talloden, Roberta	53,119.17	Wassill, Pamela	61,099.97
Tatarynovich, Emily	57,774.58	Watson, Jennifer	90,813.75
Taylor, Etta	73,859.71	Watt, Anita	102,194.55
Taylor, Tammy	70,611.32	Wehrkamp, Mary Jane	56,521.51
Teichreb, Rhonda	53,727.71	Weiman, Blair	90,019.05
Thevenot, Karen	66,739.78	Wenbourne, Kelsey	85,200.83
Thibodeau, Terry	77,492.17	Weseen, Sandra	114,925.60
Thiessen, Corey	70,244.29	Wesnoski, Barbara	92,002.85
Thomas, Krista	56,611.30	White, Dayna	54,461.68
Tiedjens, Alicia	64,718.44	White, Tanya	64,396.70
Torrance, Kristen	52,293.05	Whitehead, Merna	72,280.12
Tosh, Lee	92,429.27	Wilson, Cheri	89,536.59
Townsend, Lorna	66,170.11	Wilson, Doris	86,339.01
Toy, Yong	61,496.08	Wozniak, Deborah	74,314.21
Trites, Karen	50,562.29	Yackel, Twila	111,984.58
Trombley, Christine	70,389.46	Yaholnitsky, Pearl	102,556.38
Trombley, Sandi	51,661.21	Yaremy, Carol	70,746.43
Turcotte, Heather	75,676.02	Yelland, Wendy	61,708.73
Tyndall, Norma	102,194.55	Yeo, Charles	92,429.27
Uhryn, Chantel	93,005.99	Ylioja, Kim	65,983.36
Unger, Catherine	104,320.56	Youzwa, Sandee	61,755.06
Valeroso, Merla	54,446.17	Zacarias, Nelson	84,962.16

Zens, Arlene	112,415.31	Zuck, Paul	59,044.06
Zip, Leanne	64,340.19	Zurloff, Becky	50,612.45

Transfers

Listed, by program, are transfers to recipients who received $50,000 or more.

None

Supplier Payments

Listed are payees who received $50,000 or more for the provision of goods and services, including office supplies, communications, contracts and equipment.

3S Health (SAHO)	$3,892,816.71	Dr. Adedeji Kalejaiye	270,621.00
AMO Canada Company	169,380.78	Dr. Adeyemi Laosebikan	82,232.14
Archerwill Local # 58	212,367.76	Dr. Albert Albertyn	54,000.00
Arjohuntleigh	534,430.82	Dr. Assumpta Efobi	361,686.31
Associate Radiologists of Saskatoon	314,468.51	Dr. Bala Medical Prof. Corp	281,959.04
Baxter Corporation	62,553.25	Dr. Bronwyn Carroll	209,375.09
Beckman Coulter Canada LP	89,206.27	Dr. Bulelwa Mpisi	156,762.00
Biomerieux Canada Inc.	85,253.69	Dr. Charles Orhadje	403,533.55
Cardinal Health Canada	336,303.34	Dr. Dale Peffer	319,489.20
Carrot River Medical Clinic Inc	85,872.00	Dr. Eben Strydom	62,154.61
CDW Canada Inc	323,485.31	Dr. Eleanor Francis	345,964.20
City of Melfort	85,575.16	Dr. Gemma Nelson	245,461.23
Covidien	$117,408.09	Dr. Herbert Medical Prof. Corp.	259,160.84
CPDN/RCDP	189,896.95	Dr. Ighodalo Collins Omondiagbe	180,881.57
Crestline Coach Ltd	147,856.23	Dr. Johann Baard	359,760.37
CSI Leasing Canada Ltd	164,572.29	Dr. Jordan Wingate	180,779.25
Cummins Western Canada - S'Toon	102,913.08	Dr. Juliana Van Jaarsveld	376,846.72
Diverse Systems Ltd	193,895.46	Dr. Kayode Olutunfese	348,002.50
Diversey Canada	74,788.33	Dr. Mariusz Gurgul	144,722.00
Dominion Construction Company Inc.	1,877,457.29	Dr. Melissa Fillis	308,790.32
Dr. Abosede Adesina	265,018.30	Dr. Michael Stoll	77,104.89

Dr. Neville Van Der Merwe	366,865.80	McKesson Canada	438,345.88
Dr. Okezie Nweze	347,085.00	Melfort Ambulance Care Ltd	521,166.29
Dr. Olawumi Adeleke	51,219.63	Ministry of Central Services	622,573.43
Dr. Olumide Asaolu	269,009.15	National Refrigeration Htg Ltd.	108,473.73
Dr. Oluwafemi Adegboyega Ketiku	365,281.48	Nipawin Flight Center	114,345.00
Dr. Onose A. Lawani	339,308.05	Nipawin Medical Group	126,300.00
Dr. Pat Chernesky	73,024.33	North East EMS	1,054,415.41
Dr. Pierre Hanekom	73,786.37	North Sask Laundry & Support Services	807,267.55
Dr. Prince Manzini	260,189.93	Olympus Canada Inc	280,276.05
Dr. Rosemarie Tessa Richardson	344,432.64	Ortho-Clinical Diagnostics	347,733.91
Dunmac Construction	1,165,202.58	P3A	979,604.21
Ecolab Ltd	65,087.25	Pacific Fresh Fish Ltd.	58,215.71
eHealth Saskatchewan	140,828.92	Parkland Ambulance Care Ltd.	143,802.66
Electric Lee Ltd.	85,649.15	Philips Healthcare	209,594.85
GE Healthcare Canada	198,948.38	Physio-Control Canada Sales Ltd	63,330.78
Geanel Restaurant Supplies	76,166.02	Pineland Co-op Assoc Ltd	56,238.50
Grand & Toy Ltd	114,787.04	Prairie North Co-op Assoc Ltd	54,306.96
Great West Life	496,126.58	Public Employees Superannuation Plan	26,411.73
Health Science Association of Sask.	72,439.59	Reaume Enterprises	53,327.69
HLM Construction	1,634,831.99	RMD Project Management and Consulting	50,400.00
Honeywell Limited	354,576.32	Saputo Foods Limited	117,440.87
Hospira Healthcare Corp.	292,153.34	Sask Energy	976,205.61
Hudson Bay Medical Group	1,565,082.48	Sask Government Employees Union	1,184,839.83
Instrumentation Laboratory	59,438.94	Sask Healtcare Employees Pension Plan	10,731,010.26
Johnson & Johnson Inc	77,309.87	Sask Power	1,290,655.30
KCI Medical Canada Inc	51,237.94	Sask Tel	586,939.37
Kelvington Ambulance Care Ltd	436,879.15	Sask Workers Compensation Board	1,318,064.10
Kelvington Medical Clinic	65,549.67	Saskatchewan Union of Nurses	417,564.82
Little Rainbow Roofing & Exteriors	340,668.30	Saskatoon Regional Health Authority	375,806.45
Logibec Inc.	68,761.62	Schaan Healthcare Products	1,306,112.27
London Life Insurance Co.	96,338.00	Select Medical Connections Ltd	487,054.09
Maintenance Enforcement Office	60,000.00	Shamrock Ambulance Care Ltd	241,704.87
Marsh Canada Limited	465,621.50	Siemens Healthcare Diagnostics Ltd	256,255.01

Sisson Electric	92,582.88	Toshiba Business Solutions	175,792.82
Stevens Company Limited	205,783.45	Town of Naicam	143,553.70
Supreme Basics	56,191.96	Town of Nipawin	86,774.04
Sysco Food Services	1,429,379.97	Town of Tisdale	84,321.93
Thorpe Brothers Ltd	100,801.95	Van Houtte Coffee Services Inc	80,012.07
Tisdale Ambulance Care Ltd	509,810.57	Westmed Mechanical Ltd.	110,005.35
Tisdale Flood & Fire	123,532.69	Wood Wyant Inc	272,721.10

Sources

Government of Saskatchewan. *Ministry of Health and Healthcare System Plan for 2014-15*. Available at: http://www.finance.gov.sk.ca/PlanningandReporting/2014-15/HealthPlan1415.pdf

Government of Saskatchewan. *Saskatchewan Plan for Growth: Vision 2020 and Beyond*. Available at: http://www.gov.sk.ca/adx/aspx/adxGetMedia.aspx?DocID=3975,594,1,Documents&MediaID=4745&Filename=Saskatchewan+Plan+for+Growth+-+Full+Version.pdf

Patient First Review Commissioner's Report to the Saskatchewan Minister of Health. *For Patients' Sake.* October 2009. Available at: file:///C:/Users/pratc/Downloads/Patient%20First%20Review%20Commissioners%20Report%20(1).pdf

Saskatchewan Ministry of Health. *Patient Centred, Community Designed, Team Delivered: A framework for achieving a high performing primary health care system in Saskatchewan.* Available at: http://www.saskatchewan.ca/government/government-structure/ministries/health/other-reports/other-ministry-plans-and-reports

Sooner, Safer, Smarter: A Plan to Transform the Surgical Patient Experience. March 2010. Available at: http://www.sasksurgery.ca/pdf/sksi-planstotransform.pdf

Saskatchewan Ministry of Health. *Saskatchewan's HIV Strategy 2010-2014.* November 2010. Available at: http://www.saskatchewan.ca/government/government-structure/ministries/health/other-reports/other-ministry-plans-and-reports

Accreditation Canada. Available at: http://www.accreditation.ca/

Canadian Standards Association. Available at: http://www.csagroup.org/ca/en/services/codes-and-standards

Safety Healthcare *Now*! Available at: http://www.saferhealthcarenow.ca/EN/Pages/default.aspx

Saskatchewan Ministry of Health. 2014 *.Covered Population 2014.* Available at: http://www.ehealthsask.ca/HealthRegistries/Documents/CovPopBook2014.pdf

North East Regional Intersectoral Committee. *Northeast Housing Research Project: Housing Strengths and Gaps in Melfort, Nipawin, and Tisdale.* March 2010. Available at http://www.northeastric.ca/publications/Northeast%20Housing%20Research%20Project%20Final%20Report.pdf

Saskatchewan Food Costing Task Group. *The Cost of Healthy Eating in Saskatchewan 2012.* http://www.kelseytrailhealth.ca/Publications/ProvincialPublications/Documents/The%20Cost%20of%20Healthy%20Eating%20in%20Saskatchewan%202012.pdf

Indigineous Peoples' Health Research Centre. 2006. *Mino-Mahcihowin A Report on Indigenous Health in Saskatchewan: Report of the Indigenous Peoples' Health Research Centre.* Available at http://iphrc.ca/assets/Documents/Miyo-Mahcihowin.pdf

Statistics Canada. 2013. Kelsey Trail Regional Health Authority (Health Region), Saskatchewan and Saskatchewan (table). *Health Profile*. Statistics Canada Catalogue no. 82-228-XWE. Ottawa. Released December 12, 2013. http://www12.statcan.gc.ca/health-sante/82-228/index.cfm?Lang=E (accessed June 5, 2015).

Canadian Institute for Health Information (CIHI), 2015. *Your Health System.* Available at: http://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/theme/C7088/3/N4IgKgFgpgtIDCAXATgGxALIAYwPatQEMAHAZygBNNQAGGgRkxQFcoAaEOgJieVY7oBmXv040ALCPZiArFIE0AbPLEB2KQF8tQA

Saskatchewan Health Quality Council. 2014. *Quality Insight*. Available at: http://www.qualityinsight.ca/

Saskatchewan Ministry of Health. *Health Status Report.* Available at: http://www.saskatchewan.ca/government/government-structure/ministries/health/other-reports/health-status-reports

Government of Saskatchewan. *Working Together for Change - A 10 Year Mental Health and Addictions Action Plan for Saskatchewan.* Available at: file:///C:/Users/pratc/Downloads/Mental%20Health%20and%20Addictions%20Action%20Plan%20Full%20Report%20(3).pdf

For More Information

For further information relevant to the Kelsey Trail Health Region, contact Regional Office at (306)873-6600 or visit the following website:

Kelsey Trail Health Region
http://ww.kelseytrailhealth.ca/

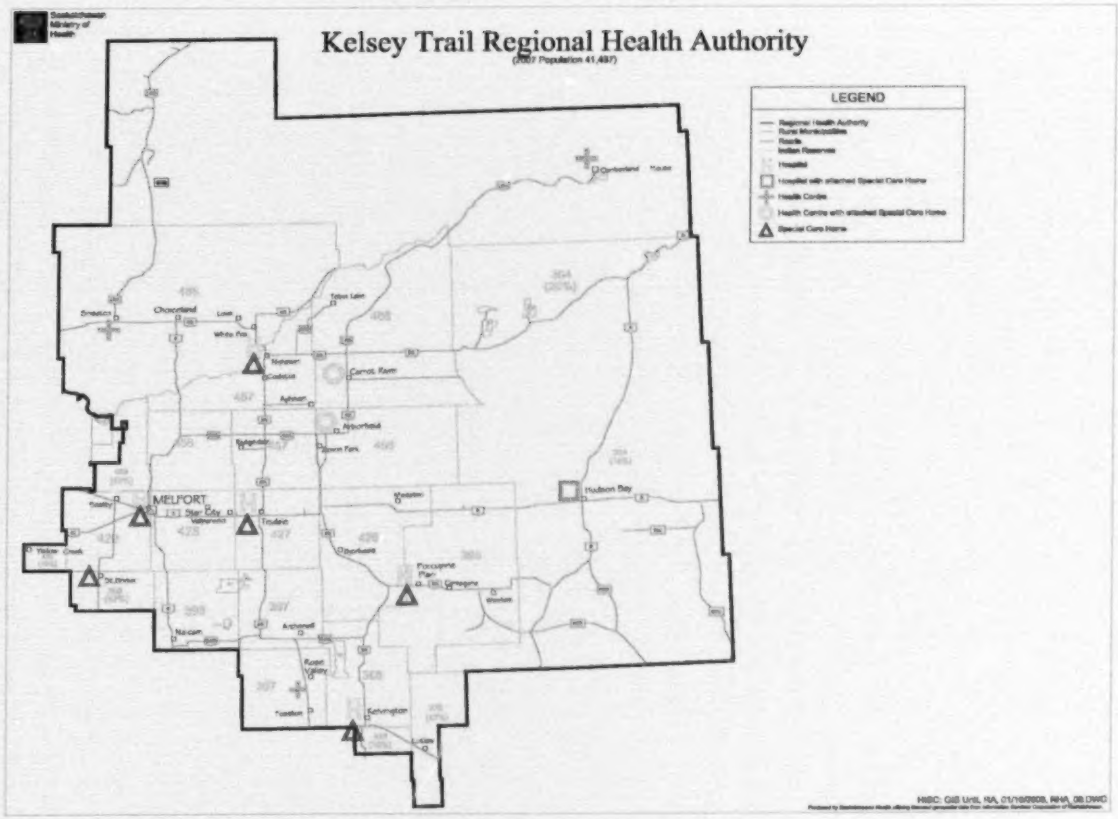
KTHR By The Numbers

During the 2014-15 fiscal year, KTHR reported:

- 3,169 acute care admissions
- 22,030 patient days
- 51,629 ER visits
- 238 births
- 303 dialysis patients
- 274 long term care admissions
- 164,996 long term care resident days
- 25,419 home care clients
- 5,059 occupational therapy visits
- 13,211 physical therapy visits
- 4,362 exercise therapy visits
- 392 speech language therapy visits
- 856 mental health clients and 7,480 mental health visits
- 360 addiction clients and 3,217 addiction client visits

Did You Know?

- ✓ Approximately 480 residents call KTHR long term care facilities their home.
  - Thirty-three residents are under the age of 65 years.
  - Ten residents are over 100 years old.
- ✓ KTHR maintained a full complement of physicians in 2014-15.
  - Dr. Gert Pieterse of Porcupine Plain was named 2014 Physician of the Year by the Saskatchewan Medical Association.
- ✓ In total, 253 new employees were hired to KTHR in 2014-15:
  - Support Services – 71
  - Continuing Care Aides – 84
  - Registered Nurses - 34
  - Health Sciences – 17
  - Licensed Practical Nurses – 8
  - Management – 1
- ✓ Lorna Hamilton, a Continuing Care Assistant at Kelvindell Lodge, was named the 2015 WorkSafe Saskatchewan Safe Worker Award winner.
- ✓ KTHR completed four Rapid Process Improvement Workshops (RPIWs)



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